Croydon Safeguarding Children Board
Serious Case Review

‘Claire’

Author: Bridget Griffin
1. Executive Summary

Context

At the heart of all safeguarding work is a hope that when, making a difficult decision to remove a child from the care of their family, the system can better safeguard the child and improve their outcomes. This commitment is enshrined in legislation and statutory guidance, it is supported by research and embedded within systems and processes, and it is intrinsic to the work carried out every day by professionals across the country.

For children who cannot be adopted or provided with permanent care by their family or kinship network, the care provided by foster carers remains the best possible environment where children can be enabled to establish healthy secure attachments with a trusted, caring adult (or adults) and assisted to reach their potential. The vast majority of children placed in foster care in the UK benefit from this care every day and for the duration of their childhood, but for a small minority of children the care they receive is harmful.

Whilst there has been recent attention given by the media to the abuse of children by adults in a position of trust, the focus of this has been largely in relation to children who are the victim of sexual exploitation. There have been fewer cases that have caught the attention of the media in relation to children in foster care, and we know very little about the extent and nature of abuse or neglect by adult caregivers in foster and residential care today.

In 2014, the NSPCC attempted to address this lack of research and in doing so looked at allegations of abuse made against foster carers and residential workers, concluding that:

The vast majority of children entering foster care are provided with safe family placements, but in approximately 450–550 cases, children across the UK do experience harm each year from those responsible for their care. This is likely to underestimate the true extent of the problem as well over half of unsubstantiated allegations could not be proven one way or the other.

In a small number of very serious cases involving the persistent neglect, emotional and/or sexual abuse of children, it was clear that the foster carers concerned should never have been recruited. High quality assessment, recruitment and review procedures are needed to prevent these individuals being able to harm children.

This serious case review examines the recruitment, assessment and approval of foster carers, but goes further than this to examine the way in which multi-agency systems safeguard children over time in the provision of a wide range of services.

Croydon Safeguarding Children Board identified that reviewing this case had the potential to shed light on particular areas of practice and raised the following questions:

- How do services work together to assess carers and match children with carers?
- How do multi-agencies work in partnership to support children with complex needs?
- How effective are multi-agency partnerships in protecting children from sexual abuse?
- How does existing partnership working (within and between systems, teams and agencies) improve outcomes for looked after children after?

1 Statutory guidance now refers to kinship carers as ‘connected persons’ thereby including all adults in a child’s network
This review set out to understand what happened to Claire and why. The SCIE\(^3\) methodology was chosen as it was believed to be the most appropriate to help answer the above questions, and to provide a window on the current safeguarding system. The review has explored why things happened, and provides Croydon Safeguarding Children Board (CSCB) with a number of findings to consider.

**What happened?**

This case involves the responses of agencies between 1st of January 2012 and the 31\(^{st}\) of January 2014. This time period was selected to provide the most useful learning about current safeguarding systems. At the request of CSCB, this review has also provided comment on an earlier period of time (when Claire was the subject of a child protection plan in her early years), as it was felt this was a critical period of multi-agency service provision that could not be overlooked.

Claire was known to multi-agency services from the age of five months. At this time, there were concerns about the misuse of drugs and alcohol in the household and domestic violence. Claire was made the subject of a child protection plan under the categories of emotional harm and neglect, and remained on this plan for a number of years. A range of multi-agency services were provided, and her safeguarding was the subject of regular monitoring and review. When Claire was six, she was sexually abused by a member of the household; shortly after this she came into the care of the local authority and was placed in the care of her paternal grandmother. After a number of months, this placement broke down and she was placed in the care of foster carers, who had been approved by the local authority. Fifteen months later, Claire was found to have contracted two sexually transmitted infections and she was removed from this placement.

Claire received services from a wide range of multi-agency professionals, and her needs were considered within multiple processes. Overall, the review identified that the multi-agency system was not always effective in translating the extensive available legislation, guidance and procedures to frontline delivery of services in the following areas:

- Rigorous assessment and approval of foster carers
- Involvement of kinship in the care and safeguarding of a child
- Practice based decision making when matching a child with carers
- Achieving full multi-agency working when seeking to protect children from harm
- Comprehensive multi-agency involvement when a child is looked after

**Why it happened**

The detailed description of what happened and the appraisal of practice is provided in section 4. Section 5 of this report provides the underlying systemic findings that give a deeper understanding of the reasons for the practice shortcomings that are described in section 4.

\(^3\) Social Care Institute for Excellence
Background

An inspection of safeguarding and looked after services in Croydon took place in June 2012. At this time, Ofsted judged safeguarding and looked after children services to be adequate (overall) with good partnership working, and good capacity to improve. It was recognised that services in Croydon contended with considerable pressure on resources in attempting to meet the needs of a large population:

Croydon is the London borough that has the highest number of children under the age of 15. The time under review includes the period Ofsted were conducting their inspection, and the 18-month period after this inspection concluded.

Findings

There are eleven findings in this review, the first of which relates to how kinship care is not sufficiently valued. Whilst the benefits of such placements are understood in principle, in practice this does not translate to an approach that consistently supports these carers to the same level as foster carers recruited by the local authority.

The next three findings are focused on the systems in place during the assessment and approval of foster carers, and the safeguards in place that support decision making on the question of suitability. Finding 4 examines an established practice in relation to male foster carers, and how this custom and practice (as it exists) has no value in either safeguarding children from harm, or supporting carers.

Finding 5 raises questions about how children are matched with carers at an early stage, and the remaining findings focus on how different agencies, services and teams work with each other, and with members of a child’s family, to safeguard looked after children and meet their needs.

An area of additional learning is presented at the end of the report: this relates to the role of managers from across services and agencies and their responsibility to provide satisfactory supervision and guidance and, critically, to challenge each other, and escalate concerns, where disagreements remain unresolved.

Could it happen again?

The findings in section 5 explain the underlying strengths and vulnerabilities in the multi-agency systems, and patterns of working relating to the circumstances in this case.

Whilst the abuse of a child by foster carers is rare, the wider circumstances of this case are not. The findings address these wider circumstances and suggest that if these issues are not addressed, the multi-agency safeguarding system will continue to have the weaknesses described, and the same practice and shortcomings could occur again.

What will the CSCB do in response?

At the end of each finding in section 5, considerations have been listed for CSCB. At the request of CSCB, this report goes further and raises questions for relevant agencies. These questions are aimed at assisting the Board and individual agencies to decide on the optimum action to take; they are not an exhaustive list. The intention of these questions is to prompt debate and challenge, within and across agencies, about how improvements will be realised. In response to this serious case review, CSCB has prepared a separate document outlining the work that is to be taken forward.
2. Introduction

Why this case was chosen to be reviewed.

Croydon Safeguarding Children Board Serious Case Review Sub-Group considered the circumstances of this case in November 2013, when it was agreed that agencies would examine their case records and bring information back to the sub-group. The sub-group considered the case again in January 2014 and March 2014 and a decision was taken that the case did not meet the threshold criteria for a serious case review; instead Children’s Social Care agreed to undertake an ‘Individual Management Review’ (IMR). The National Panel of Experts were critical of this decision and asked to see the IMR when it was completed. A draft IMR was presented to the July 2014 sub-group and was re-presented to the Croydon Serious Case Review Panel on the 25th of September 2014. The circumstances of this case were reconsidered, and the previous decision reviewed. It was agreed that the criteria, outlined in statutory guidance4 for undertaking a serious case review, had been met.

On the 7th of October 2014 Croydon Safeguarding Children Board (CSCB) decided to review this case using The Social Care Institute for Excellence (SCIE), Learning Together Case Review methodology5.

The National Panel were notified of the decision on the 1st of October 2014 and the 31st of October 2014.

Summary of the Case

Claire’s family had been known to Children’s Social Care (CSC) since 2005. Her mother had three children, of whom Claire was the youngest. The concerns in 2005 related to domestic violence, drug and alcohol misuse, and were of such concern that all the children were placed on child protection plans from 2006 until 2010, under the categories of neglect and emotional abuse.

The case was closed in 2010, after it was decided that Claire no longer needed to be the subject of a child protection plan. Shortly after this, when Claire was four, she was found alone wandering in the street as she had been locked out of the family home. The case was re-opened to CSC and an Initial Assessment completed. Claire was deemed to be a ‘child in need’ and support services were provided to the family.

In January 2012, whilst Claire was sleeping in bed with her mother, she was sexually abused by a family friend. Two days later, mother contacted the police and a child protection investigation commenced, followed by a child protection case conference. Claire was made the subject of a child protection plan for neglect and sexual abuse. Those at the conference felt Claire should be removed from the family home as a matter of urgency. An application for an Emergency Protection Order was lodged at court in January 2012, and then withdrawn. Later that month, Claire was accommodated6 and became a ‘looked after child: she was placed within the care of her paternal grandmother. Two months later, paternal grandmother reported she was unable to cope with Claire’s behaviour and a local authority foster placement was sought.

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4 Working Together to Safeguard Children. HMG 2013
5 Fish, Munro & Bairstow 2010
6 Sc20 Children Act 1989
A couple, newly approved by the fostering panel, were considered as a potential placement for Claire and, after introductory visits, Claire was placed with these carers. Early concerns expressed by the female foster carer about the demands of the fostering role led to the provision of a range of support services. Over the duration of Claire’s placement, a number of concerns emerged about the carers but overall it was felt the placement was going well; Claire’s permanent care within this family was thought to be the likely long term outcome. An Interim Care Order was granted in August 2012, and a Care Order in June 2013.

Later that year, in August 2013, Claire was removed from this placement after contracting gonorrhoea and chlamydia, and she was placed in an emergency foster placement. In November 2013, Claire moved to live with specialist carers and remains in this placement to date.

Organisational Learning and Improvement

Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews, states:

‘Reviews are not ends in themselves. The purpose of these reviews is to identify improvements that are needed and to consolidate good practice. LSCB’s and their partner organisations should translate the findings from reviews into programmes of action, which lead to sustainable improvements, and the prevention of death, serious injury or harm to children’.

Structure of the report

The report is structured as follows:

- Section 3 explains the methodology used for this serious case review
- Section 4 explains what happened, why and gives an appraisal of practice in this case
- Section 5 provides the findings and suggests what needs to happen in the multi-agency safeguarding systems to reduce the risk of recurrence
- A glossary of terms and abbreviations used is provided at the end of the report

3. Methodology

Introduction

Statutory guidance (Working Together 2015) requires that serious case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.
In order to comply with these expectations and requirements CSCB has used the full version of the SCIE Learning Together Systems model\(^8\) for this review. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families, and make it more or less likely that the quality of practice will be good or poor. Solutions then focus on redesigning the system to make it easier for professionals to safeguard children well and harder to safeguard children poorly.

**Review team and independence**

The process has been led by Bridget Griffin and Ghislaine Miller; the final report was written by Bridget Griffin. Both are independent reviewers with significant experience of writing serious case reviews and they are accredited by SCIE to lead serious case reviews using the Learning Together methodology.

These lead reviewers worked closely with a review team consisting of a group of senior managers who worked collaboratively with the lead reviewers in reading documentation, talking to staff, and analysing data.

The review team were also able to provide useful information regarding the practice in this case, and evidence about whether the issues relevant to this case had wider significance. Those involved were:

- Manager, Croydon Safeguarding Children Board
- Head of Service, LAC and Resources Croydon LA
- Specialist Crime Review Group, Met Police
- Head of Safeguarding, Designated Nurse Safeguarding Children, Croydon CCG
- Designated Nurse LAC, Croydon Health Services
- Croydon Education Safeguarding Leads
- Designated Doctor for Child Protection, Croydon CCG

The lead reviewers received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and the reliability of the findings as rooted in evidence.

**Data collection: practitioners and records**

Understanding practice in context requires reviewers to engage those people who were directly involved in the case in a collaborative process of dialogue, as well as drawing on the formal documentation as a source of data. Input from the key practitioners (called the ‘case group’) has been generated via individual conversations, supplemented by two case group meetings, when practitioners were given the opportunity to discuss, correct, amplify and challenge the accuracy of the facts identified, and the interpretations made, by the review team, and to share their knowledge of the systems as a whole.

In total, 27 conversations were held, 8 meetings took place, and over 60 documents reviewed. Membership of the multi-agency case group and the review team numbered over 45 and included, but was not exclusive to, the following members of staff:

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\(^8\) Fish, Munro and Bairstow, 2010
- Social Workers x 5
- Team Managers x 5
- Primary School Teachers x 2
- Teaching Assistant
- GP
- Health Visitors x 2
- Paediatrician
- Police x 3
- Independent Reviewing Officer
- Child and Adolescent Mental Health Services x 2
- Independent Fostering Agency Supervising Social Worker and Team Manager
- Children’s Guardian (CAFCASS)
- Local Authority Designated Officer
- Delivery Managers (Children’s Social Care) x 2
- Fostering Panel Advisor (at the time)
- Independent Fostering Panel Chair
- Agency decision maker (Fostering)
- Representatives from the Business Resource Team (Children’s Social Care)

Data from Family Members

The lead reviewers met with Claire’s paternal grandmother, her aunt and her mother. All family members clearly welcomed the opportunity to express their views. The information they provided was critical, and can be seen in several of the findings. In particular, their perspectives have contributed to the formulation of findings 1 and 11. Understandably, members of Claire’s family are deeply distressed by what they have learnt about Claire’s experiences. They had all believed that ‘by giving Claire up to be cared for by the state’ (none of the family members contested the Care Proceedings), they were placing her in the care of a trusted system that would be of long term benefit to Claire. To learn of Claire’s experiences has clearly brought about feelings of anger and regret, and deep sadness for Claire. The review team are immensely grateful to members of Claire’s family for agreeing to participate in this review.

Methodological Comment and Limitations

When initially considering membership of the review team, there were four professionals who had a possible conflict of interest as they had had some contact with Claire or decision-making in the process. However, as Claire was a child who had been the subject of extensive multi-agency involvement, it was concluded that it would be difficult to identify review team members who had not been involved in the case in some shape or form. Following a period of discussion and challenge, it was agreed that these possible conflicts would be acknowledged through the process and that peer challenge and scrutiny would be a welcome feature of this review.
4. Appraisal of professional practice

Introduction

This case involves the response of agencies between January 2012 and January 2014 to a young child who was receiving universal and specialist services as a child in need, a child in need of protection, and a looked after child. There were a multitude of professionals involved in providing services to Claire under the review timeline, she was the subject of many assessments, carried out by staff across a range of disciplines and services, and her needs were considered within a range of multi-agency assessments and processes.

Working at the front line of a complex system, with children who have suffered harm or who are suffering harm, is extremely challenging. It goes without saying that the events of this case had a significant impact on professionals involved, both at the time the events were happening and during this serious case review. That said, practitioners and managers who were directly involved in providing services to Claire engaged well with this review. The nature of the Learning Together methodology allows front-line practitioners to reflect on their work and to strengthen their knowledge of multi-agency systems and processes, as well as providing an opportunity to promote their professional learning. Many have commented that being part of this review has allowed them to achieve a depth of learning that will have a lasting impact on their professional work in safeguarding children.

This section provides an overview of what happened in this case and why. Sometimes the explanations for why will be explained in the findings section of the report and a cross reference will be provided in this section. Along with the explanation of what happened, the following makes explicit the view of the review team about the timeliness and effectiveness of the responses provided to Claire and her family, including where practice was below expected standards. Such judgements are made in light of what was known and was knowable at that point in time. The name of the child, foster carers and professionals that were involved, have been anonymized.

Local Context

During the last Ofsted inspection of looked after services and safeguarding arrangements in Croydon in June 2012, Ofsted judged services to be adequate (overall) with good partnership working, and good capacity to improve. The Ofsted report made the following observation of Croydon:

*Croydon is the second most populous borough in London, with a population of 345,600, including approximately 89,200 children aged 0-19. Croydon is a socio-economically diverse borough. The borough is ranked 19th out of 32 London boroughs in terms of overall deprivation and 107th out of 326 local authorities in England.*

The local authority and multi-agency partners contend with considerable pressure on resources: Croydon remains the second highest populated borough in London with 84,000 young people under the age of 15, the largest number of any other borough. It has the highest number of looked after children compared to all other London boroughs and consistently has a higher number of unaccompanied asylum seekers than any other local authority.

In terms of the CSC workforce, the local authority struggled for some time to recruit permanent members of staff and as research shows this can have a significant impact on the quality of work that can be achieved. At the time Claire was first placed on a child protection plan in 2009, only 40% of the staff were permanent and, although this number improved to 85% in 2012, it was observed by Ofsted that "many of the social workers are relatively newly qualified".
The report adds that “[t]he quality of service is improving, but from a low base. Some known weaknesses, such as the quality of work with children in need, have yet to be fully tackled to improve the performance of front line social work services”.

**Significant dates in the period under review**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>7.1.12</td>
<td>Claire is sexually assaulted by a 32-year-old friend of her eldest brother.</td>
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<td>9.1.12</td>
<td>Mother contacts the Police after Claire discloses sexual abuse to mother’s friend.</td>
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<td>10.1.12</td>
<td>Child protection medical; significant bruising found and additional concerns are identified in relation to neglect.</td>
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<td>12.1.12</td>
<td>Police and Children’s Social Care commence a joint child protection investigation (Section 47, Children Act 1989).</td>
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<td>25.1.12</td>
<td>Initial Child Protection Conference. Professionals voice frustration that Claire is still living at home.</td>
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<td>25.1.12</td>
<td>Foster Care Assessor concludes the assessment of Mr and Mrs George.</td>
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<td>26.1.12</td>
<td>LA lodges an Emergency Protection Order (EPO) application with the court; EPO is not progressed. Mother agrees to Claire and Sibling 2 being accommodated by the LA. Claire is placed with her paternal grandmother and Sibling 2 with a different paternal grandmother.</td>
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<td>14.1.12</td>
<td>Fostering Panel review the assessment of Mr and Mrs George; Mr and Mrs George are approved as foster carers.</td>
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<tr>
<td>14.1.12</td>
<td>First Looked after Child (LAC) Review.</td>
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<tr>
<td>21.2.12</td>
<td>Claire is interviewed by the police and discloses sexual abuse. Police suspect this is not an isolated event.</td>
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<td>20.3.12</td>
<td>For a number of weeks, Claire’s paternal grandmother expresses concern that without support she is unable to care for Claire. After 2 months an alternative placement is requested.</td>
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<tr>
<td>28.3.12</td>
<td>Review Child Protection (CP) Conference for Claire and Sibling 2. Children’s names are removed from a CP plan as they are now both looked after by the local authority.</td>
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<tr>
<td>April/May ‘12</td>
<td>Mr and Mrs George are identified as possible foster carers for Claire; a period of introduction commences.</td>
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<tr>
<td>23.4.12</td>
<td>Pre-Placement Planning Meeting: Mr George and Mrs George are advised that males in the house, including Mr George, must not be alone with Claire.</td>
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<tr>
<td>27.4.12</td>
<td>Letter of intent (local authority’s intention to apply for an Interim Care Order) is sent to Mother and Father.</td>
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<tr>
<td>9.5.12</td>
<td>Claire’s spends her first overnight stay with Mr and Mrs George (part of planned introduction). Second LAC Review held: Care Plan confirmed as long term fostering.</td>
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<td>10.5.12</td>
<td>Child protection referral is made by Claire’s school expressing concerns about Claire.</td>
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<td>11.5.12</td>
<td>Mr and Mrs George are told of concerns reported by the school: Mr George responds angrily.</td>
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<td>14.5.12</td>
<td>Claire is placed with Mr and Mrs George.</td>
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<td>15.5.12</td>
<td>Mrs George found to be in distress: she is struggling to care for Claire and requests her removal from the foster carer’s home.</td>
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<td>16.5.12 – 6.6.12</td>
<td>Mrs George makes regular contact with CSC stating she no longer wants to be a foster carer. She identifies Claire’s behaviour as the source of her distress and requests Claire is immediately removed from the placement.</td>
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<td>7.6.12</td>
<td>Mr and Mrs George report Mr George is now taking a more active role in caring for Claire; as a result, placement is regarded as stabilising.</td>
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<td>2.7.12</td>
<td>Problems with Claire’s bedtime routine are reported by carers; Claire’s school reports concern that Claire is assaulting other children.</td>
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<tr>
<td>31.8.12</td>
<td>Interim Care Order is granted. Parents do not contest proceedings. Father previously</td>
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<td>expressed a wish to care for Claire but provided no formal response as part of the</td>
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<td>proceedings; mother told the court she was unable to care for Claire.</td>
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<td>3.10.12</td>
<td>Third LAC Review held at Claire’s foster placement with Mr and Mrs George.</td>
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<td>15.10.12</td>
<td>Case transferred to a different social work team, the Looked After Children (LAC)</td>
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<td>Team.</td>
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<td>19.3.13</td>
<td>Annual Review of Foster Carers. Fostering Panel express concerns about Mr and Mrs</td>
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<td>George; particular concerns relate to Mrs George’s ambivalence towards Claire, and</td>
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<td>her own unresolved emotional needs. Decision about continued approval is deferred.</td>
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<tr>
<td>20.3.13</td>
<td>Fourth LAC Review held.</td>
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<tr>
<td>14.5.13</td>
<td>Fostering Panel review approval of Mr and Mrs George. Panel receive updated information</td>
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<td>about the suitability of Mr and Mrs George and recommend continued approval.</td>
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<tr>
<td>24.6.13</td>
<td>Care Order granted for Claire (Section 31, Children Act 1989).</td>
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<tr>
<td>8.8.13</td>
<td>Mrs George telephones the GP regarding Claire having vaginal soreness and asks for</td>
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<td>cream to be prescribed. GP examines Claire and is concerned that Claire has a</td>
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<td></td>
<td>sexually transmitted infection. Swabs are taken and CSC contacted; GP expresses</td>
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<td></td>
<td>concern that Claire is unsafe; Mrs George is informed. Decision is taken by CSC not</td>
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<td>to take any action until swab results known.</td>
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<td>12.8.13</td>
<td>Swab results confirm Claire has gonorrhoea and chlamydia; GP confirms results with</td>
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<td>CSC. Allocated social worker and foster carers’ supervising social worker visit the</td>
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<td>placement; Mr George leaves the family home overnight and Claire remains in placement.</td>
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<td>13.8.13</td>
<td>Local Authority Designated Officer (LADO) Strategy meeting: police express significant</td>
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<td>concerns that Claire remains at significant risk. Child protection investigation is</td>
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<td>initiated; Claire is removed from the placement and placed in an emergency foster</td>
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<td>placement.</td>
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<td>23.8.13</td>
<td>Police interview Mr and Mrs George; nothing of significance emerges.</td>
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<td>4.9.13</td>
<td>ABE interview with Claire; Claire does not disclose abuse.</td>
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<tr>
<td>12.9.13</td>
<td>Second LADO strategy meeting: Mrs George tested positive for gonorrhoea and Mr George</td>
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<td>tested positive for chlamydia; it was felt Mr George may have received treatment for</td>
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<td>gonorrhoea before test was done.</td>
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<tr>
<td>18.9.13</td>
<td>Third LADO Strategy Meeting.</td>
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<tr>
<td>30.11.13</td>
<td>Claire moves to live with specialist carers.</td>
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<tr>
<td>21.1.14</td>
<td>First LAC Review in new placement. Claire has settled well; placement noted to meet</td>
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<td>her needs.</td>
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**Appraisal of Practice Linked to the Findings**

The Learning Together methodology intentionally focusses on a period of time that is most relevant to current practice and systems. The reason for this is that practice and systems can change rapidly over time in response to learning and improvement, changes in the workforce, and wider local or national changes of government, legislation and associated guidance. Therefore, the period under review (1st January 2012 to 31st January 2014) was selected as the period most relevant to current systems learning. However, CSCB felt it was important to comment on the early period of Claire’s life, in order to understand more about Claire’s early years and to identify any possible learning that may still be relevant.
The period prior to the time under review

Shortly after Claire’s birth, the children in the family were made the subject of Child Protection Plans under the category of emotional abuse, and remained on Child Protection Plans for four years. The case notes over this period of time have not been scrutinised as part of this review, but from the account given by Claire’s mother (when she was spoken to as part of this review) it is clear that during this time Claire witnessed frequent violence which at times was extreme.

The names of the children were removed from Child Protection Plans when it was believed Claire’s mother had made a number of improvements in her parenting, and after four months the case was closed to CSC. Seven months later, Claire was found wandering the streets as she had been locked out of the family home; concerns were expressed about drug and alcohol misuse and violence within the household. This prompted the re-involvement of CSC, and a child in need service was provided to the family under section 17 of the Children Act 1989

Appraisal: The length of time Claire was the subject of a Child Protection Plan was unacceptable: the impact of early trauma on children has been well researched and the effects of this trauma are likely to remain with Claire throughout adulthood. A much earlier decision should have been taken to remove Claire from this household. Had there been adequate consideration of Claire’s future, it would have been clear that Claire’s paternal grandmother was willing to provide care, but this was never explored.

The ending of Claire’s Child Protection Plan may well have been indicated at the time, although without analysis of the records it is not possible to know this with certainty. Given that only a few months later the original concerns returned it seems highly likely that the assessment which concluded sufficient changes had been made was overly optimistic and not predicated on a sound evidential base. When speaking to Claire’s mother as part of this review, she was invited to reflect on this period of time:

*I was in relationships with men that were regularly violent…..sometimes this violence was extreme, I could not break out of these relationships; this is what I needed help with, but help was not given. I found the help for myself in the end and attended a self-help group. I now understand that I was in a cycle I could not break out of…. when I went to court at the time I told them I was not a fit mother. After getting the right help I am now in a relationship with a man that is not violent.*

Since this time, there have been a number of significant changes in the length of time children are the subject of a Child Protection Plan, with an increased emphasis on children remaining on Plans for a maximum of two years. Performance and quality assurance measures are in place to enable this data to be reported to senior managers, and compliance is the subject of regular review. Therefore, the considerable practice changes to this safeguarding work since 2005 means that no findings are made in relation to this period: the changes in practice, existing quality assurance and reporting mechanisms are understood to be adequate.

The period under review

Allegation of sexual abuse and child protection medical, January 2012: The history of the family was one of emotional abuse and neglect; the circumstances of the sexual abuse allegation (including information that mother was drunk at the time) demonstrated that there had been no sustainable changes in mother’s ability to protect her children from abuse. Despite this, Claire remained living at home for twenty days after the allegation of sexual abuse was made. The social worker to the family was newly qualified. This social worker was committed to her work with the family, had a good relationship with mother and felt that mother would make every effort to protect Claire: she ensured mother signed a written agreement to this effect.
The use of a written agreement to seek assurances from parents is common practice; they are promoted by managers, and their use is often endorsed by legal advice, but their efficacy has not been the subject of review. Management supervision should have challenged the optimistic view of this newly qualified social worker, and the use of a written agreement, particularly in circumstances such as this where a parent is known to misuse alcohol, should not have been encouraged. This practice was not based on a sound evidence base, and was not the subject of sufficient management support or guidance. This is discussed further in the additional learning.

The child protection medical was carried out by an experienced clinician and was good practice. It was well documented and made clear findings and important observations about neglect.

**Initial Child Protection Conference, January 2012:** The Initial Child Protection Conference was timely, well attended and well chaired. Members of the multi-agency group rightly voiced concern that Claire remained living at home and the conference correctly made a recommendation that Claire should be the subject of an Emergency Protection Order (EPO). After the conference, the social worker lodged an application for an EPO hearing with the court; this was good practice. However, the EPO was not pursued, because mother agreed to Claire being accommodated by the local authority. This is in line with expected practice: legal proceedings should be avoided if parental agreement to a child’s care can be gained. However, it was the view of the multi-agency group that in Claire’s specific circumstances, a court order was required to allow the local authority to share parental responsibility for Claire. Despite being informed that this recommendation was not followed, members of the multi-agency group, including the conference chair, did not escalate their concerns. This fell below expected practice: a safe system requires multi-agency partners to challenge practice where it falls below expected standards. Issues regarding the absence of multi-agency engagement in decision making for children in the care of the local authority are explored in finding 8. Issues regarding the absence of multi-agency challenge are explored further in the additional learning.

**Claire’s accommodation and placement with paternal grandmother, January 2012:** On removal, Claire was placed with her paternal grandmother under Section 20 of the Children Act 1989. This was good practice as children should be secured within their birth families whenever possible and Claire was close to her grandmother: she spent every weekend in her care and had her own bedroom in the house. The social worker rightly completed a viability assessment, but the full assessment that was required (a Regulation 24 assessment) was not completed. This should have been started immediately; failure to do this meant that there was no assessment of the paternal grandmother’s capacity to care for Claire, no assessment of the support she required and no assessment of any potential risk the birth father may have posed. The lack of support provided to the paternal grandmother had a direct impact on the placement later breaking down. This practice fell below expected standards and, had the correct level of support been provided, it may have been entirely possible that Claire could have remained within the care of her extended family. Claire’s social worker was newly qualified and she was a busy front line first response social worker dealing with the immediate protection of children on a daily basis. She did not understand that the assessment needed to be passed to a different social work team, and she was not appropriately guided in her work. In addition, the organisational culture that appeared to prevail was that kinship care was not valued in the same way that care provided by in-house foster carers was and this, combined with the limited integration of the different social work teams working with the needs of looked after children, contributed to this placement breaking down.

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9 The lack of clarity in relation to the possible risks posed by birth father contributed to later confusions during a time when critical decisions needed to be made about Claire’s protection.
The issues in relation to how kinship placements are valued are explored in finding 1, issues in relation to the integration of different social work teams are explored in finding 9, and the quality of management supervision and guidance is explored in the additional learning.

First LAC Review, 14th February 2012: This first review was critical: it was an opportunity to intervene early to avert the potential of drift and delay in care planning. The review was correctly held within the required timeframe. The social worker was late in letting the LAC Review Service know of the need to convene a LAC Review, the social worker had no experience of working with looked after children and existing processes in place meant that it was the allocated social worker, rather that the LAC Review Service, who were responsible for making arrangements for LAC Reviews. The Independent Reviewing Officer (IRO) knew that the timeliness of reviews was an important performance indicator, so the review was arranged quickly at the social worker’s office. There was no consultation with Claire, Claire’s parents, her paternal grandmother or with any other agency: this contravened statutory guidance. Issues in relation to how the contribution of family members is valued in the life of a looked after child are explored further in finding 11.

The IRO was allocated seventy to eighty cases; this case load exceeded national guidance and left the IRO with little time to think or reflect on Claire’s case. The IRO was keenly aware which performance indicators had to be covered within the review and made sure they were properly covered; as a result the meeting focussed on performance indicators relating to Claire’s health and education. Claire’s complex emotional needs, her placement with her paternal grandmother and her legal status and care plan were not discussed in any meaningful way. The care plan described in the review (as Claire remaining with her paternal grandmother long-term under section 20) should have been the subject of challenge: Claire was a very young child, her permanent care through adoption or through a Special Guardianship Order should have been thoroughly explored. The quality assurance systems in place measured particular performance indicators in respect to LAC Reviews; quality was not measured against the IRO regulations, and IROs were under pressure to ensure that these specific performance measures were covered; this narrowed the IRO’s focus. These issues are explored further in finding 10.

Assessment and approval of Mr and Mrs George as foster carers, 14th February 2012: The assessment of Mr and Mrs George was completed using a standard Form F assessment tool. The tool is in widespread use across the country and the format ensures all required fostering competencies are covered. Although the assessing social worker was new to the role, all obligatory areas were covered within the assessment and a great deal of information was provided to evidence the competencies. However, the form did not promote sufficient critical appraisal of the information gathered, and as a result there was an absence of analysis. These issues are explored further in finding 2.

The assessing social worker was employed on an independent sessional basis by the local authority; it is not unusual for fostering assessments to be completed by independently employed sessional workers. However, this meant that the social worker did not have accesses to routine management supervision or guidance. Before the assessment went to panel, the assessment was seen by a manager. This manager did not identify the absence of analysis as, in line with expected standards, the focus of quality assurance was not on the quality of analysis but on whether the required competencies had been properly covered.

The social worker attended the fostering panel with Mr and Mrs George. Panel members asked very few questions about the content of the assessment, but did ask Mr George how he would manage allegations made against him. He responded saying he would not be left alone with a female foster child and his answer was accepted without question. The assessment was agreed by the panel and Mr and Mrs George were approved as foster carers.
Within the Form F information was presented that required further exploration, scrutiny and analysis. The relevant issues.

Finding 5 explores the relevant issues.
Review Child Protection Conference, 28th March 2012: At this time, Claire was the subject of a Child Protection Plan under the categories of neglect and sexual abuse. The Conference heard from the social worker that after receiving legal advice there had been a decision not to proceed with an application for a court order; the decision to proceed with a voluntary agreement with parents rather than pursue a legal route was in line with preferred practice. At the Conference, members rightly raised significant concerns that Claire had not been made the subject of legal proceedings. Additional concerns were expressed about her placement with her paternal grandmother, and the unassessed risks potentially posed by Claire’s birth father. However, in line with expected practice, as Claire was now looked after, a decision was taken that her Child Protection Plan would end and that no further Conferences would take place.

The logic that informs this expected practice is that if a child is looked after they are adequately safeguarded, because they are the subject of additional processes such as court proceedings and Looked After Children reviews: it is assumed that these provide the required safeguarding mechanisms. Hence, having an additional Conference process in place is regarded as superfluous, and an unnecessary drain on resources that are already over-stretched. This is understandable, and is an approach widely taken across the country. However, in cases where a child is not the subject of court proceedings, and where risks remain unresolved, this blanket approach is unsafe. In addition, the expectation that the LAC Review process will involve the required multi-agency representation and adequately interrogate the safety of a child, was not borne out in practice. Despite significant concerns being expressed by multi-agency partners during the conference, there was no effective challenge to the decision to end Claire’s Child Protection Plan. The absence of effective multi-agency challenge fell short of expected practice, is contrary to procedures, and did not provide adequate safeguards. These issues are explored further in finding 6 and in the additional learning.

Second Looked After Review meeting, 9th May 2012: This second LAC Review followed the same format as the first LAC Review. In addition, the membership, venue and timing of this review were contrary to the IRO Regulations and the relevant section of the child protection procedures was not followed; this practice did not provide adequate safeguards and fell below expected standards. The competing demands and the organisational pressures experienced by IROs (resulting in a dilution of their responsibilities under the IRO Regulations), have already been outlined and are explored further in finding 10. In addition, the assumption that existing processes will provide adequate safeguards for a child was not embedded within established practice or process and as a result was not borne out in practice. These issues are further discussed in finding 6.

Pre-placement planning meeting, 23rd April 2012: In line with expected practice and procedure, a pre-placement planning meeting was held at the home of Mr and Mrs George. The foster carer’s supervising social worker attended alone and although this is not uncommon, it would have been best practice if Claire’s social worker had been invited. The purpose of the meeting was to plan how Claire’s needs would be met in the placement, and to identify what support the carers may need. During this meeting, the fostering social worker told Mr George that he must be careful not to be alone with Claire; Mr George agreed. This was not an unexpected request as Mr George had already given assurances to the fostering panel to this effect. Although the requirement that Mr George should not be alone with Claire was a routine request made of male foster carers caring for a child who has been the victim of sexual abuse, and was supported by management guidance, it was an unreasonable request that could not be adequately monitored or assured. These issues are further explored in finding 4.
After the meeting the supervising social worker returned to her office and, in line with routine practice, placed the notes of the meeting in the fostering file. There was no communication with Claire’s social worker and, as Claire’s social worker did not have access to these notes, she was unaware of the meeting, or of the requirement that Mr George was not to be alone with Claire. This lack of joint working fell below expected practice, led to disunity in the frontline teams and created gaps in the understanding and meeting of Claire’s needs. The reasons for these practice shortcomings are outlined below and explored further in finding 9.

Multi-agency responses to concerns about Claire, 10th May 2012: After Claire had spent her first overnight stay with Mr and Mrs George, as part of a planned introduction to the placement, she was observed at school to be walking ‘splay legged’ and complained that her vagina was sore. School staff knew her well as she had been at the school since her reception year, and this behaviour was uncharacteristic. The school contacted the social worker and suggested that a strategy meeting was needed. The social worker was newly qualified and she appropriately sought advice from her manager about this request. The manager felt that Claire’s behaviour may have been linked to her previous abuse and, as Claire had not made a disclosure, it was decided that a strategy meeting was not needed, but that Claire’s paternal grandmother should be asked to take Claire to the GP. The school were informed of this decision; they were unhappy with the response but were not sure what else they could do. Issues in relation to management guidance and multi-agency challenge are explored further in the additional learning.

No strategy meeting took place, there was no child protection medical and there was no child protection investigation. This was contrary to the child protection procedures and fell below expected practice. This approach was indicative of a poorly developed understanding of the value of strategy meetings. These issues are explored further in finding 7.

Response to concerns in placement, 15th May to 7th June 2012: The day after Claire’s was placed with Mr and Mrs George, Mrs George telephoned her supervising social worker in a distressed state; she told her social worker that she was unable to care for Claire and wanted her to be immediately removed from the placement. The supervising social worker arranged to visit the placement the next day; this was a timely visit. During the visit, Mrs George became distressed and spoke about how difficult she was finding the fostering role. The supervising social worker spoke to her manager about this. It was the manager’s view, informed by significant experience in the fostering service, that this was not an unusual reaction for a couple who were new to fostering. A good package of support was offered to the carers in response to Mrs George’s concerns. Two weeks later, the couple confirmed that things had settled down; it was reported that Mr George was now caring for Claire until their adult daughter took over care when she came back from work, thus relieving Mrs George.

The communication between the supervising social worker and Claire’s social worker over this period was minimal. The words used by Mrs George when describing how she felt about caring for Claire should have prompted far greater curiosity and analysis by the fostering team, and should have been shared with Claire’s social worker, but this did not happen. In addition, there was no challenge to the information received that Mr George was now playing a key role in Claire’s care, and again this information was not shared with Claire’s social worker. The social worker and the supervising social worker worked in different teams; they had different roles and responsibilities; were managed by different line managers; and used different data recording systems. Close working relationships between these social workers was therefore difficult to achieve and, whilst there were no structural barriers to achieving a close working relationship, the structures in place did not sufficiently facilitate this relationship.
In practice, close working relationships were largely dependent on the relationships achieved by individual workers. These issues are explored further in finding 9.

**Third Looked after Review Meeting Mr and Mrs George’s home, 3rd October 2012:** There are no minutes on file of this meeting; the reason for this is not known. The absence of such an important record falls below expected practice standards.

During the course of this review it was understood that by this time Claire’s medical had taken place and a number of health needs had been identified. However, there was no representation of the LAC nurse at this meeting. In addition, by now Claire had been the subject of significant multi-agency involvement and specialist assessment and intervention, but despite the close involvement of agencies in Claire’s day to day life, including Claire’s school, none of these professionals or agencies were represented at this important planning meeting. This left decisions solely in the hands of the local authority and this single agency approach did not meet Claire’s complex needs. It was understood that this is often a feature of LAC Reviews and planning meetings for looked after children and, whilst there is a strategic multi-agency commitment to sharing responsibility for looked after children and their outcomes, there is little in place to facilitate this on the front line in a way that makes a difference to children. These issues are further explored in finding 8.

**Renewal of Mr and Mrs George’s approval as foster carers, 19th March to 14th May 2013:** The approval of Mr and Mrs George as foster carers was the subject of a routine annual review on the 19th March 2013. During this review, panel members were rightly concerned about the suitability of Mr and Mrs George as foster carers. Concerns were focussed, not on the role of Mr George, who it was argued had a strong commitment to caring for Claire in the long term, but on concerns about the emotional health of Mrs George, her ambivalence towards Claire, and towards her fostering role. Information provided to the panel by the fostering team on these issues was inadequate, and as a result panel members had differing views: four panel members recommended the decision should be deferred until more information was made available, three panel members recommended the carers should be de-registered and two recommended the carers should not be re-approved. The panel chair made the decision to defer concluding the matter until more information was available. Claire’s social worker was unaware of the concerns held by panel and was unaware of the panel’s decision. The reasons for this are outlined previously and explored further in finding 9.

At the next panel meeting on 14th May 2012, Mr and Mrs George attended. A revised report was provided by the fostering team and Mr and Mrs George answered questions put by the panel. The panel were told that Mr and Mrs George were now both fully committed to Claire, and to their fostering role. Information provided by the fostering team in support of the recommendation for continued approval included confirmation that Mr George was now playing an active role in caring for Claire. Additional information was provided that Mrs George was taking medication for panic attacks and was on the waiting list for counselling, and as a result her emotional health had improved. On this basis of this new information, the panel recommended continued approval. The information provided to the panel stated not only that Mr George was actively caring for Claire, but that he was often alone in her company. Despite the existing agreement that Mr George should not be alone with Claire, this was not questioned by the supervising social worker, or by the manager who signed off the report, or by the Panel or later by the Agency Decision Maker. The lack of sufficient scrutiny of the information provided to support the continued approval of Mr and Mrs George by managers and panel members meant that decision about the suitability of Mr and Mrs George was highly questionable. The issues raised previously, in relation to the poorly developed quality assurance mechanisms in place when deciding foster carer suitability, are explored further in finding 3.
Professional response to the GP's concerns about Claire, 7th August 2012. Mrs George noted Claire had a vaginal discharge; she bought some cream from a pharmacy but there was no improvement. She then contacted her GP asking for some cream to be prescribed. The GP asked for Claire to be brought to the surgery that day; this was good practice. The GP examined Claire and took a number of swabs, she was very concerned by what she observed and about Claire’s immediate safety; she spoke to Claire in the presence of a chaperone: this was good practice. She informed Mrs George she would be contacting CSC as she was concerned for Claire’s safety and made immediate contact with CSC and spoke to the social worker; this was good practice. On receiving the call, the social worker was extremely concerned: as she was not in the office because she was responding to an urgent matter on another case, she asked the GP to contact her manager and also contacted the manager herself; this was in line with expected practice. The GP contacted the manager and gave her opinion that Claire had a sexually transmitted infection and was at risk. After discussion with another manager, a decision was taken to await the swab results before taking any other action. The manager informed the GP of this decision; the GP correctly told the manager she was extremely concerned by this response and went on to make numerous phone calls to health colleagues in an attempt to elicit a different response from CSC. The perseverance of the GP was commendable but, despite the number of calls made by the GP, health professional colleagues were unable to escalate the concerns effectively and there was no strategy meeting and no child protection investigation. The reason for this is believed to be directly related to a misunderstanding about the value of strategy meetings when a child is looked after. These issues are discussed further in finding 7.

The next day the Local Authority Designated Officer (LADO) was contacted by the manager; the LADO agreed with the decision to await the swab results before taking any action. The response by CSC managers (including the LADO) and the lack of action taken was contrary to the child protection procedures, left Claire at risk of harm and fell well below expected practice. The reasons for this are linked to the issues outlined in finding 7 and were compounded by the issues explored in the additional learning.

Professional response to the swab results, 12th to 13th August 2013: On 13th August 2013, the GP contacted the social worker confirming that Claire had chlamydia and gonorrhoea. The social worker was shocked by what she was told. She was not in the office that day but made immediate contact with a senior manager and made arrangements to return quickly to the office; this was good practice. The senior manager had limited experience of child protection work and so the child protection procedures were not well known to her; she also had limited knowledge of sexually transmitted infections and so when she was contacted by the GP she sought assurances that the infection could not be caught from something other than sexual contact/abuse. She was not convinced by the answers she was given, or that Claire was unsafe in her placement. She spoke to a colleague in the fostering team and together they reached a view that as Claire’s father was a Schedule One offender, and Claire was spending alternate weekends in the care of her paternal grandmother, there was a chance that she may have been infected by someone outside the placement, or that the infections had remained dormant from when Claire had been sexually abused whilst living with her mother. A decision was made that the social worker and the supervising social worker would visit the placement, speak to Claire and the carers with the view to removing Claire from the placement.

The social worker returned to the office and sent a police notification form and a Local Authority Designated Officer referral form to the senior manager and, together with the supervising social worker, visited the placement. The reaction of Mr and Mrs George to the information that Claire had sexually transmitted infections was one of anger.
Mr George became particularly angry and abusive; Claire witnessed this anger and was distressed. As directed by the senior manager Claire was spoken to alone by the social worker; she did not make any disclosures.

The social worker made regular calls to the senior manager; she was expecting the police to arrive at the house to assist but when they did not arrive, and the situation became increasingly untenable, she asked the senior manager for the police to be called. The senior manager had not contacted the police because she did not think they would be in the office as it was out of normal office hours; furthermore, she was not keen to have the police visit the home of a foster carer. Eventually, in an effort to minimise further disruption for Claire, a decision was taken by the senior manager that Claire would remain in the placement and Mr George would spend the night in another household. This was contrary to advice given by the Head of Service at an earlier point that Claire should be removed from the household. However, it was late in the evening, the senior manager was aware that her decision making was trusted by the Head of Service and an extreme situation had been reached, so she felt in a position where a judgement call needed to be made.

The social worker was not happy with this decision or with the way in which the situation had been managed by the senior manager: she felt very concerned for Claire and did not want to leave her in the placement, but it was now very late at night and she felt she had been left with no alternative. The social worker was new to her role and although a competent and committed practitioner she felt she had no option other than to follow the direction and guidance of the senior manager. She did not know what else she was able to do.

The issues in relation to management supervision and guidance are explored further in the additional learning.

It was the view of an experienced Director of Children’s Social Care who was in post at the time these events occurred, that the decision not to remove Claire was a judgement call that did not contravene existing child protection procedures. There remains a divergence of views about this: it was the view of a number of review team members that the guidance provided by CSC managers, the lack of a strategy discussion with the police and the lack of joint action with the police fell below expected practice, was contrary to child protection procedures and to statutory guidance, and compromised Claire’s emotional wellbeing and safety. That said, in the absence of required action in response to the concerns raised the previous week, in the absence of a strategy meeting or discussion that day, and in circumstances where a child is experiencing considerable emotional distress caused by witnessing anger and hostility within a household for some considerable time, to reach an agreement that a male carer will leave the house rather than remove a child is a judgement call, and on balance, in these extreme circumstances, is one that is arguably justifiable.

Issues relating to how strategy meetings are valued are explored further in finding 7.

\textbf{Strategy Meeting, 13th August 2012:} On the advice of the LADO, a strategy meeting was held the next day. This was well attended by professionals representing the police, health services and CSC and a decision was taken to remove Claire from her placement that day; this was the correct decision. Claire was immediately removed to a place of safety; this was expected practice. Information was held by Claire’s school, but this information was not sought. If contact had been made with the school, information would have come to light at an early stage that would have informed a better understanding of Claire’s experiences.
Claire’s paternal grandmother had recently provided respite care for Claire. She had important information about Claire’s discharge and had also been given information by Mrs George about a previous visit to the doctor and a diagnosis of thrush: this information was in fact untrue. As the paternal grandmother was not contacted as part of the strategy meeting process, she was not able to share this information: this fell below expected practice. The contribution family members can make in the protection of children is understood but not fully realised, and this has a significant impact on how information held by family members is sought and used to inform safeguarding decision making. These issues are explored further in finding 11.

5. The Findings

Introduction

Statutory guidance requires that serious case review reports provide a sound analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of re-occurrence. Section 4 provides the analysis of what happened and why; section 5 provides the findings relating to what needs to happen in the multi-agency safeguarding systems to reduce the risks of re-occurrence.

The SCIE Learning Together systems approach uses what has been learnt about an individual case to provide a ‘window on the system’ into how well the local multi-agency safeguarding systems are operating.

In what way does this case provide a useful window on our systems?

CSCB was understandably very concerned about what had happened to Claire and sought to understand her experiences as a child who had been in receipt of many multi-agency services from a very early age. It was felt vital not only to learn about what had happened in this case (as described in section 4), but also to consider what this tells us more generally about the way agencies in Croydon individually and collectively respond to safeguarding children when they are a looked after.

The contextual information provided in section 4 provides a general picture of judgments made in Croydon’s Ofsted inspection and of improvements made at that time, but the judgements do not address the specific circumstances seen this case. This case provides evidence of multi-agency working after the period under inspection and covers a number of areas that have previously not been the subject of investigation, audit or analysis.

Summary of findings

This section contains eleven priority findings that have emerged from the serious case review. The findings explain why professional practice was not more effective. Each finding lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding is indicative of potential risks to other children in future cases, because they undermine the reliability with which professionals can do their jobs. It does this by considering patterns that are supportive of good quality work and patterns that introduce or increase the risk to the reliability with which we can expect professionals to achieve good quality work.

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10 Working Together to Safeguard Children DfE 2015
The eleven priority findings relate to five underlying patterns within multi-agency safeguarding systems. No single finding can explain the outcome; all the findings are interrelated: one impacts on the other and the other impacts on the next and so on. The evidence for the findings comes from the knowledge and experience of the review team and case group, from the records relating to this case, case documentation and from relevant research evidence. Quotes from the case group and the review team are used in the findings; these are direct quotes taken from the words of an individual professional, and are chosen because they are felt to best represent a view expressed by a number of case group and review team members during the course of this review.

The remainder of this section explores the eleven Findings.

Findings in detail

Finding 1: Patterns of interaction with family members

The difference in how connected carers are valued, and so supported, in contrast to ‘in house foster carers’, increases the likelihood that children are unable to grow up in the care of connected carers/family members.

Introduction

When a child becomes looked after by the local authority a decision must be taken about where the child is best placed in order for their needs to be met. There are a number of options that are considered in making this decision: for younger children either a foster placement, or a placement with members of the extended family or with connected persons, are the placements of choice. In an emergency, children can be placed with connected persons or family members who have previously not been assessed, as long as a viability assessment is completed. Following this, these carers are subject to an assessment and approval process that largely mirrors the assessment and approval process of other foster carers. In the same way, these carers are joined in all relevant processes, procedures, standards and quality assurance mechanisms as applied to all children’s placements in foster care. Likewise, these carers are equally entitled to the same financial assistance, training and support packages that are provided to other foster carers. The challenges of caring for looked after children, who have frequently suffered abuse and/or neglect in early childhood, are often significant and the support provided to their carers is pivotal in enabling such placements to be successful. This case has shown that there is a difference in the way these different carers are valued and supported.

How did this feature in this case?

When a decision was taken to remove Claire from her mother’s care and accommodate her within the care of the local authority, Claire’s mother agreed to her paternal grandmother looking after Claire. The social worker completed a viability assessment and Claire was placed in her care. Paternal grandmother did not understand that Claire was now a looked after child; she simply assumed that Claire was staying with her as she usually did every weekend and every school holiday, but that this time her stay included weekdays. The bin liner of clothes that she came with was found to contain dirty ill-fitting clothes. The paternal grandmother bought her new clothes and a school uniform. Money was tight and all incoming money was already accounted for, so the additional financial pressures proved to be difficult to manage.
The paternal grandmother was not aware that she was able to gain financial support: she was not told of this and so did not ask for it. The demands of the paternal grandmother’s job meant that she worked long days, and often worked for six days of the week: it was a struggle for her to meet the practicalities of caring for a young child. Claire’s behaviour was challenging, she was exhibiting emotional distress and her behaviour was difficult to understand. The paternal grandmother often asked CSC for support; she was seen as very demanding. Eventually, the demands of caring for Claire became too difficult for the paternal grandmother to manage and she informed the social worker that she was no longer able to cope with her care. By this time Claire had been with her paternal grandmother for almost four months, but no formal connected person’s assessment had been completed, no therapeutic services or guidance had been provided, and no financial assistance had been given.

In contrast, when Claire moved to live with Mr and Mrs George, who had been assessed and approved as professional foster carers by the local authority, the carers were provided with a weekly financial allowance and a clothing allowance to meet her needs. Respite care was provided every other weekend, child care was provided to allow the foster carers to go on holiday, after school activities, breakfast club, and summer camps were funded, and the carers were provided with the support of a mentor. There were regular visits by Claire’s social worker and the carers received support from their fostering supervising social worker; a CAMHS tier 4 team provided therapeutic support to the carers.

**How do we know it is not unique to this case?**

Members of the case group were clear that statutory guidance promotes the placement of a child within the care of extended birth family members, and efforts should be made to support these arrangements. Whilst it was understood that this is the starting position, it was felt that this did not necessarily translate to the same level of support as that provided to foster carers recruited by the local authority: *We do not invest enough in family, it is potentially the best option for a child and is more cost effective* (front line practitioner).

In terms of why this might be the case, members spoke about differences in the processes in place for the assessment of family members, and the additional work that is inherent in supporting birth family members as carers. In the case of in house carers, the necessary work at the early stage of recruitment is completed by the fostering teams and a supporting social worker is allocated (the supervising social worker). For family carers or connected persons, the checks and the initial viability assessment are completed by the child’s allocated social worker before the case is passed to the Fostering Team and allocated to a supervising social worker. This is both sensible and reasonable, as it is this child’s social worker who often knows the child and family best. However, this work can be difficult to prioritise for social workers and they may de-prioritise full completion of this early stage of work, in a working environment where the immediate need to achieve safety for a child dominates much of their work. It was understood that this can cause delays in completing the work needed to transfer the case to the fostering teams, as it did in this case.
Whilst these practical difficulties were widely acknowledged as very real obstacles, it was felt that this was not the central nub of what may lie beneath the differences in the support provided to the two different kinds of carer. What came across was a sense of a distinctly different attitude towards family carers in comparison to other foster carers, a view that family carers do not require the same support as other foster carers because the child is believed to be known well by these family members, and a belief that families have a moral obligation to provide care. It was concluded that this leads to workers sometimes not perceiving the provision of support to family/connected person carers to be urgent. When combined with the impact of practical differences inherent within existing processes, this leads to these carers being valued, and consequently supported, in a very different way.

**How widespread and prevalent is the issue?**

There are numerous pieces of national research examining this issue, and unanimous agreement that there is a real difference in the support offered to connected persons, as compared to in house carers:

*It is clear from the research that the support offered to kinship foster carers varies greatly and the support, finance and training available to kinship carers is often of inferior quality to that offered to non-kinship carers.*

In 2013, The Buttle Trust reviewed relevant research and interviewed 80 children and kinship carers. This research found that the lack of support to kinship remains a concerning trend:

*Despite taking on a huge burden from the state by looking after children who would otherwise end up in the care system, kinship carers and the children they look after are still an overlooked group who experience high levels of poverty and disadvantage with little or no statutory support.*

Government statistics on the numbers of children in formal connected persons care show that at 31st March 2013, 11% of children (over 7,000) looked after in England were fostered by a relative or friend (DfE, 2013). No data is available in relation to the levels of support provided to connected persons.

Between January 2013 and December 2014 in Croydon, ninety carers were approved as foster carers; fourteen of these were connected persons (15.55%). There is no data available on the number of connected persons placements that break down as a result of lack of support, or the number of placements that are made where financial or other support is (or is not) provided. Consequently, it is not possible to provide statistical data in relation to how connected persons/carers are supported in Croydon.

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11 How do kinship (family and friends) foster carers experience their role and working relationships within the children's workforce? CWDC 2009
12 “The Poor Relations? Children and informal carers speak out”: The Buttle Trust
What are the implications for the reliability of the multi-agency safeguarding system?

There is a widespread recognition that children who cannot live with their birth parents should be given the chance to be looked after by family members/connected persons rather than strangers, if this is in the child’s best interests. If placements with connected persons are properly resourced and supported they have the potential to offer children permanence, stability and a sense of belonging which other kinds of care placement cannot always provide. In a system that is working to preserve children’s care with their birth families, efforts will be made to establish mutually respectful relationships with birth family members as soon as they become known to the local authority, so that a positive working relationship can be established and a tailored package of financial, practical and emotional support provided to enable them to offer the best possible care to their child.

However, connected persons face many challenges, often linked to their own circumstances, the complex emotional and behavioural needs of the child they are caring for, the financial demands of caring for a child, and the difficult dynamic that can exist between them and the child’s parents. If a system does not properly recognise and promote the benefits for looked after children of finding permanence within their birth families or the support for connected persons is not adequate, connected persons are likely to struggle with the challenges of caring for their child and may ultimately find this so overwhelming that the child’s placement breaks down.
Finding 1: The difference in how connected carers are valued, and so supported, in contrast to ‘in house foster carers’, increases the likelihood that children are unable to grow up in the care of connected carers/family members.

Summary: Legislative guidance, backed by research findings, is clear: wherever possible children should be placed within the care of their birth family because such placements have clear lifelong benefits for a child. However, supporting connected persons carers can be complex. The mixed organisational messages about the value of connected persons, if not resolved, can leave practitioners trying to resolve these contradictions on the front line. Without the necessary organisational supports in place, such efforts will inevitably have little impact.

Issues for the Board and Individual Agencies

Children’s Social Care
- How will the support currently provided to existing connected carers be reviewed and evaluated?
- What steps will be taken by CSC to identify any cultural attitudes or beliefs or organisational obstacles that may get in the way of providing sufficient support to connected carers and how will improvements be made?
- Does innovative practice exist elsewhere and can this be built upon in Croydon?
- Is it possible to conduct a focus group with family carers to better understand what support they need and how this is best delivered? Do current arrangements provided to support in house carers need to be adapted so they meet the needs of family carers- Would a more tailored approach be helpful?
- What training is currently provided about the value of family placements and how such placements can be identified and best supported?
- What data should now be collected in relation to connected carers and what quality assurance measures need to be in place to examine this area of work?
- How are placement disruptions currently managed? And how can the learning from any breakdowns or disruptions be used to inform future developments?
- Are there any systems issues, in relation to both supervision and the electronic systems in use that guide the flow of work (ICS), that could be adapted to embed changes that will support practitioners and managers in the timeliness of assessments and in the provision of support?
- Learning and development plans for respective teams and for the service to reflect the learning from this finding and issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

Issues for Croydon Safeguarding Children Board
- CSCB to decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.
Assessment and approval of Foster Carers (Findings 2 & 3)

The assessment and approval of foster carers takes place within a tried and trusted process that involves the completion of an assessment form and a process of scrutiny and quality assurance provided by suitably experienced managers, and an independent panel. The following two findings are two aspects of this system and, whilst inextricably linked, are separate aspects of the system and need to be considered in their own right. Therefore, these findings are presented separately.

**Finding 2: Tools**

The tool used in the assessment of foster carers appropriately encourages the gathering of information guided by fostering standards. However, this is not sufficiently balanced by a focus on critical appraisal and this has a detrimental impact on the quality of analysis in the assessment of potential foster carers.

**Introduction**

When prospective foster carers are assessed in relation to suitability, statutory guidance\(^\text{13}\) provides the broad framework for assessment, detailing the areas that must be covered and the information that must be gathered during this assessment. The guidance states that *

> [t]here are no specific requirements about the way in which assessment information must be collected or presented to panel.

Assessments are routinely undertaken using a standard template known as the ‘Form F’. This template was designed by the British Association for Adoption and Fostering (BAAF)\(^\text{14}\). A licence is paid to BAAF in order for the form to be used and this form is in routine use across the country (to such an extent that the term ‘BAAF Form F’ is synonymous with ‘a fostering assessment’); no other forms are known to be in use.

Whilst the associated guidance states the need for scrutiny and analysis of the information gathered, the form does not provide explicit prompts to facilitate this; it is assumed this will be completed by the assessor or will be picked up by the quality assurance mechanisms in place. This finding illustrates how, in the use of an assessment form primarily focussed on a list of competencies, the decision making about suitability can become inadvertently led by a need to ensure these competencies have been met, rather than assessment and decision making involving critical appraisal and analysis that may reveal important information on the question of suitability.

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\(^{13}\) Assessment and approval of foster carers: Amendments to the Children Act 1989 Guidance and Regulations Volume 4: Fostering Services July 2013

\(^{14}\) Prospective Foster Carer(s) Report (Form F) (England) BAAF
How did this feature in this case?

The Form F provided a great deal of information about Mr and Mrs George. The information provided followed the standard structure of a Form F, charting how Mr and Mrs George met the necessary fostering competencies and foster care standards. The information covered a wide variety of areas pertaining to Mr and Mrs George, with the vast majority of information taken directly from the words of the couple. As a result, the information presented in the assessment took the form of descriptive accounts; there was an absence of critical appraisal and analysis and this impacted on decision making in respect to suitability. This is illustrated in a variety of ways within the Form F. The following information provides two examples.

The Form F contains long quotes from Mr and Mrs George about their own childhoods: the couple describe these childhoods in very positive terms. Phrases such as having a great life and having a happy childhood are used interchangeably by both Mr and Mrs George. However, from both carers’ accounts, there were indications that these childhoods were not quite as they were described.

For Mrs George there were clear issues regarding her relationship with her birth father and her stepfather, both of whom left the family home when she was a child. There were unanswered questions concerning the identity of her birth father, and there remained issues relating to secrecy and truth in relation to this important issue. These issues remained unresolved at the time of the assessment and were not commented on or explored during the assessment. In addition, Mrs George was known to have a serious life threatening health condition which, although being successfully treated, was something she was continuing to emotionally process; this was not the subject of sufficient exploration.

Mr George spoke in glowing terms about his childhood. However, within the narrative there were clues concerning a number of emotional issues that remained unrecognised and so potentially unresolved. These included descriptions of his mother being emotionally unavailable to him – she was not physically affectionate… She put up with me – and of his father:

He was not an emotionally warm or affectionate man who would not like him (Mr George) showing his feeling or crying…to this day Mr George finds it hard to talk about his feelings when he is upset, and never cries.

These accounts appear as a narrative of facts and the conclusion in the report is that Mr George has experienced a stable, committed family and he has experienced reliable, loving and caring parenting.

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

How do we know it is not unique to this case?

The messages from the case group and from conversations with managers, practitioners and panel members responsible for the completion, review and scrutiny of Form Fs, were consistent:
Form Fs are a reputable tool used to assess the suitability of foster carers; they have been used for a number of years and so are an established bedrock in the assessment of foster carers and, apart from an increased focus on foster carer competencies, they have changed very little over the last ten years.

There was a strong reluctance to question the format and use of the Form F: it was clear that its use is so part and parcel of the culture that questioning this bedrock led to many challenges and a desire to draw the focus of enquiry towards the individuals involved. Whilst the notion that this may be a one off (an issue peculiar only to this case) was considered, the fact that the assessment went through a number of different quality assurance layers, involving individuals at different levels of management hierarchy, and involving a panel of independent members, led to the conclusion that this finding was not peculiar to this case. Indeed, the unanimous view of the case group and review team, who were familiar with Form Fs, was that this assessment was of a ‘good quality’ (it was no different to the quality of the Form Fs routinely seen by the Fostering Service, the Panel, and the Agency Decision Maker).

A number of case group members spoke about how Form Fs have come to be seen as just a ‘means to an end’, in relation to the approval of foster carers. There was information to suggest they are not routinely read or used to inform the ongoing work with carers, or to inform how a child’s needs will be met in the placement, and it was generically felt that apart from listing how the fostering competencies have been met, these forms had no other value.

A member of the review team expressed their professional view, based on many years of experience in fostering services, that the emphasis of the Fostering Standards (2011) has drawn local authorities into a position where the form F is disproportionately slanted to an assessment process that leads down a path of using the form to assess foster carers to become foster carers. Hence, the result is an emphasis on gathering information in order to complete a check list of competencies, rather than an emphasis on information scrutiny, based on critical appraisal and analysis.

How widespread and prevalent is the issue?

BAAF Form Fs are the only forms in use in Croydon for the purpose of foster care assessment, and are widely used across the country to inform the assessment and approval of foster carers. Despite calls to improve the quality of fostering assessments, and recommendations to move to a ‘value based’ or ‘adult attachment style’ of assessment (NSPCC 2013), there is no research and no local or national data on this issue. However, it is perhaps noteworthy that serious case reviews examining the abuse of a child in a position of trust over recent years have highlighted the need to have in place assessments that prioritise information gathering characterised by close careful appraisal and analysis, over information gathering led primarily by the need to show whether or not competencies have been met.

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15 There have been a number of inquiries into abuse in foster care, including the inquiries into the deaths of Shirley Woodcock (1984), Chelsey Essex (2007), and into cases where foster carers have been imprisoned for the abuse of foster children, including Eunice Spry, Kenneth Norton and two foster carers in Wakefield who sexually abused a succession of foster children (Parrott et al., 2007). More recently the report of a court case, A and S (Children) v Lancashire County Council [2012], documented the physical abuse of two siblings in two of the many foster placements they had lived in over an 11-year period (Conroy, 2012).
What are the implications for the reliability of the multi-agency safeguarding system?

The assessment of foster carers is part and parcel of the way in which vulnerable children are safeguarded and their needs met within the care of the Local Authority.

The safe and effective assessment of foster carers for this critical caring role is carried out daily across the country in order that children who are unable to live within the care of their birth family can make secure attachments and grow up to reach their potential in the care of a substitute family. If foster care assessments get beneath the narrative by exploring values and motivations, and conclusions are predicated on critical appraisal of the information gathered and analysis, the question of suitability can be properly determined and suitable carers recruited.

Information gathering in order to evidence how standards are met, whilst useful, is only one part of the assessment process. Adults who intend to sexually abuse children are often sophisticated in their attempts to be in a position where they may gain the opportunity to carry out this abuse and they will look for ways of outmanoeuvring whatever assessment processes are in place to avoid detection. If foster carer assessments are led by a format that promotes gathering information to evidence whether a list of competencies have been met and does not balance this with a format that facilitates robust critical appraisal and analysis, this creates a potential loophole that risks manipulation by adults who are potentially unsuitable, thus undermining the systems designed to protect children from harm.
**Finding 2:** The tool used in the assessment of foster carers appropriately encourages the gathering of information guided by fostering standards, however this is not sufficiently balanced with a focus on critical appraisal and this has a detrimental impact on the quality of analysis in the assessment of potential foster carers.

**Summary:** The assessment and approval of foster carers is a critical cornerstone in how children are safeguarded, and how their needs are met. Many foster carers are successfully recruited across the country and provide a high standard of care to vulnerable children. The assessment form in use lists the foster care standards and competencies required by national guidance, and this is appropriate. However, the lack of emphasis on critical appraisal and analysis of this information creates potential loopholes that undermine the quality of decision making when question of suitability is decided.

**Issues for the Board and Individual Agencies**

**Children's Social Care**
- How might the assessment tool in use be adapted to promote strengthened critical appraisal and analysis?
- Is there innovative practice elsewhere that can built upon?
- How might the benefits of using the principles of value based motivational interviewing be considered when assessing foster carers?
- Have the benefits of an adult attachment interview been considered in the assessment of foster carers?
- How might the training of assessing social workers be strengthened to promote critical appraisal and analysis of the information gathered?
- Could agencies be better engaged in the assessment of foster carers in a way that supports analysis of the information gathered (such as the involvement of a mental health professional)?

- Learning and development plans for respective teams and for the service to reflect the learning from this finding and issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

**Issues for Croydon Safeguarding Children Board**
- CSCB to decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.
Finding 3: Management Systems

There are a number of quality assurance measures in place to enable the successful assessment and approval of foster carers, but these measures are inhibited by an absence of sufficient scrutiny and challenge. This compromises decision making on the question of suitability.

Introduction

The completion of a foster care assessment is only the start of an established process of review and decision making before the question of approval is concluded. This process involves a manager responsible for foster care assessments, a Panel made up of experienced independent members, and a nominated ‘Agency Decision Maker’ (usually a senior manager). The Agency Decision Maker has the final say in foster care approval. Accordingly, this strict process is a core quality assurance mechanism that facilitates how the question of foster carer suitability can be decided. In order for this to work well, the process must be predicated on robust challenge, scrutiny and analysis. This case has shown that when these features are absent, the approval of foster carers is compromised.

How did this feature in this case?

There was information contained within the assessment of Mr and Mrs George that was presented to Panel which suggested this was a family where secrets and dishonesties were an accepted part of life. As described in the previous finding, this was something Mrs George had grown up with. The assessment completed by the assessing social worker identified that the parents had not told the truth to their children about Mr George’s previous marriage. In this assessment there was additional information provided that the couple had not told their children the truth about their own marriage: the children had been led to believe the parents had been married at an earlier point in their relationship, so when Mr and Mrs George told them they were getting married the children were really angry—— they felt they had been lied to.

There were significant discrepancies in the dates given by the couple regarding when they had met and started an intimate relationship. These dates were significant as Mr George was married when the couple met and, given the birth date of their eldest child, it was entirely possible that an intimate relationship commenced within months of his first marriage (when Mr George was still living with his wife in the marital home). The number of discrepancies in the dates given by the couple suggested the couple were keen to ensure that the truth about this was not the subject of exploration, and indeed it was not.

All of this information was clear to see within the assessment, and within this assessment there were other areas of the couple’s life that should have posed questions in relation to their honesty (e.g. suggested fraudulent use of a disabled ‘blue badge’ parking certificate).

The responsible manager picked up on the issue of Mr George’s previous marriage and the fact that his children had not been informed, but apart from this none of these issues were raised by managers, panel members, or by the Agency Decision Maker. Consequently, there was no interrogation of these secrets and dishonesties, and no analysis of the possible implications.
How do we know it is not unique to this case?

Conversations were held with a number of the case group members who held responsibility for the assessment and approval of foster carers: these included the Panel Chair, Panel Adviser, and the Agency Decision Maker. Collectively, these members had many years of experience in the assessment and approval of foster carers. The view of these members was that the carers *looked good on paper*, the assessment was of the same quality as the majority of assessments that go to panel, and in hindsight there was nothing memorable about the information provided in the assessment.

The assessing social worker told members of the review team of recent discussions with colleagues about attendance at panel; their experiences suggested a consistent absence of in depth scrutiny and challenge, and a view that panel members were focused on typing errors, or on more practical aspects of the assessment in relation to such things as the financial status of the couple and whether the required fostering competencies had been covered.

How widespread and prevalent is the issue?

Although there is no local or national data or research relevant to this particular finding, it is noteworthy that research and serious case reviews examining the safe recruitment of adults in a position of trust emphasise the need for sufficient scrutiny and analysis to be present, not just in the completion of an assessment but in all stages of the recruitment process:

*In a small number of very serious cases involving the persistent neglect, emotional and/or sexual abuse of children, it was clear that the foster carers concerned should never have been recruited. High quality assessment, recruitment and review procedures are needed to prevent these individuals being able to harm children.*

An experienced senior manager expressed the view that *assessment is disproportionally slanted to approving foster carers*, and so it may be of relevance to note that in Croydon between January and December 2013, there were 37 foster carer assessments presented to panel, all carers (100%) were approved. In 2014, 56 carers were presented to panel, 54 were approved (96%).

What are the implications for the reliability of the multi-agency safeguarding system?

There are over 63,000 children placed in foster care in the UK. The vast majority of children entering foster care are provided with safe family placements; this is achieved through a tried and tested process of assessment and approval that includes suitably experienced managers, independent experts, and multi-agency specialists, with the ultimate decision resting with an experienced senior manager. In a system that is working well, the suitability of potential carers is determined by assessment and decision making characterised by robust analysis, scrutiny, debate and challenge.

In the absence of these features, unsuitable adults will be in a position of caring for vulnerable children, compounding existing problems that the child may have, and causing further harm. High profile cases of children abused by adults in a position of trust has shown that when the rigour of the recruitment process is comprised, this makes it more likely that unsuitable adults will be able to manipulate these gaps in order to have access to children.

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17 Bichard Warner Utting et al
Finding 3: There are a number of quality assurance measures in place to enable the successful assessment and approval of foster carers. These measures are inhibited by an absence of sufficient scrutiny and challenge, and this compromises decision making on the question of suitability.

Summary: Foster carers are tasked with the safe care and nurture of vulnerable children. The assessment of ‘in-house’ foster carers falls to the local authority: approval is the subject multidisciplinary review and decisions are made within a carefully established process that includes the involvement of independent panel members. For this system to work safely, in approving suitable foster carers and protecting children from harm, the vital role played by scrutiny and challenge must be fully realised and consistently delivered.

Issues for the Board and Individual Agencies

Fostering Panel
- What are the obstacles to achieving scrutiny and challenge of foster care assessments?
- Is the Fostering Panel made up of the necessary expertise to allow informed analysis of the information provided?
- How do panel members gain specialist advice when needed?
- What is the role of the Panel Advisor and how are any potential conflicts of interest understood and managed?
- What quality assurance mechanisms are in place to review and evaluate the work of the Panel? How is performance measured?
- How is the Independent Chair supported in raising and resolving any concerns in relation to the work of the panel?
- Fostering Panel learning and development plan to reflect the learning from this finding and issues to be taken forward.
- Fostering Panel to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

Children’s Social Care
- What are the obstacles to achieving high quality assessments?
- How is quality assurance (under the current arrangements for commissioning assessments) provided? Are these arrangements adequate?
- What is the role of the Agency Decision Maker? Are there any obstacles in how this role is fulfilled? Are there any potential conflicts of interest?
- CSC Learning and Development Plan to reflect the learning from this finding and issues to be taken forward.
- CSC to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.
Issues for Croydon Safeguarding Children Board

- CSCB to decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.

Finding 4: Patterns of multi-agency working in longer-term work

The established norm of seeking a commitment from male foster carer that they will not have unsupervised contact with a female child in their care to avoid allegations being made, provides a veneer of assurances that the child and carer are safeguarded.

Introduction

Statutory guidance contained within Working Together\(^\text{18}\), sets out the responsibilities of Local Authorities and multi-agency partners in dealing with allegations made against staff in a position of trust. Allegations made against foster carers, whilst not a significantly prevalent issue, are not uncommon: a recent study by the NSPCC reports a UK estimate of approximately 2,000–2,500 allegations per year. Between one-fifth and one-quarter of these allegations (22–23 per cent depending on year) were confirmed as abuse or neglect. The majority of allegations were therefore not substantiated. In a sub sample of 85 local authorities 26 per cent of all allegations were confirmed and 30 per cent were considered to be unfounded. However, 43 per cent of allegations were unsubstantiated due to a lack of evidence to either prove or disprove them. Since the 1980s, the Fostering Network and its predecessor the National Foster Care Association (NFCA), have drawn attention to allegations of abuse against foster carers,\(^\text{19}\) describing how unfounded allegations can be profoundly upsetting for foster carers, can lead to the removal of children from their care, and may result in some carers giving up fostering. It is therefore unsurprising that fostering teams and panels are mindful of this issue when working with foster carers. The response to this issue by fostering services and panels is varied; in Croydon a particular approach has been taken and this approach has become a routine part of practice.

How did this feature in this case?

In line with expected practice, Mr and Mrs George attended the fostering panel to answer questions put by the panel to assist the panel in making a decision about their approval. Within the assessment information was provided outlining how the couple would share the care of a child: *Mrs George would care for the child until Mr George returned from work…. He would then be able to do what was needed for the child while Mrs George was at work.* Prior to approval being recommended, Mr George was asked how he would manage the potential of allegations being made against him by a child in his care; he responded by saying that he would ensure he was ‘never alone with a female placement’ and the panel accepted this answer. The panel made a recommendation to the Agency

\(^{18}\) Working Together to Safeguard Children, DfE 2013 & 2015

Decision Maker that Mr and Mrs George should be approved as foster carers. This recommendation was signed off by the Agency Decision Maker, and Mr and Mrs George became approved foster carers for Croydon.

Subsequently, Claire was placed in their care. Prior to this placement being made, a ‘Pre-Placement Planning Meeting’ was held. During this meeting Mr George was asked for assurances that he would not be alone with Claire; these assurances were given, and accepted without question.

During the early days of Claire’s placement, Mrs George struggled with her fostering role and made a number of requests for Claire to be removed from the placement. Subsequently, it was confirmed by Mr and Mrs George that in response to these difficulties Mr George was taking an active role in supporting his wife in caring for Claire. As a result it was unsurprising when it was confirmed that Mr George took Claire to her contact with birth mother, and when visiting the carers at their home the supervising social worker found Mr George home alone with Claire. This change in the arrangement was reported to the Fostering Panel in support of their continued registration, and was accepted without question.

**How do we know it is not unique to this case?**

Information gathered during conversations and meetings with case group members confirmed that there was a standard requirement for male foster carers to make a commitment never to be alone with children who had been the victim of sexual abuse: *it is standard safeguarding practice* (manager). It is an expectation routinely set by fostering teams, and is regarded by the Fostering Panel as an acceptable way in which allegations against carers can be managed.

When the Review team dug beneath this issue, it was equally clear that this is an expectation that in reality is unreasonable and that no one expects to be followed: *Everyone would have known it was unworkable, it is an extreme position... No one thought it would be followed and so no one was surprised when it wasn't.* (Manager).

**How widespread and prevalent is the issue?**

As stated above, this expectation is set as a requirement for every foster placement made in Croydon for a child who has been the victim of sexual abuse. When drawing from the experiences that the case group had had with fostering panels, and fostering services more widely across other local authorities, it was understood this is not unique to Croydon. This expectation is set up in this way, not on the basis that the male carer would pose a risk, but in order to protect foster carers from potential allegations of sexual abuse being made by a child. It is not an area that has been the subject of audit either locally or nationally and as a result there is no relevant research or data available.
What are the implications for the reliability of the multi-agency safeguarding system?

Many children who have been the victim of sexual abuse are provided with safe nurturing care within the care of families that include male members in a caring role. The role modelling by male family members of an appropriate loving relationship based on clear boundaries and a love that is unconditional (not based on what the child can provide to the adult, or on a relationship tainted by grooming or abuse), provides an optimal environment where a child can heal the wounds of past trauma caused by sexual abuse. There is no doubt that a child who has experienced such significant trauma can present unique challenges to carers in their attempts to meet the child’s considerable needs. To meet these challenges by setting unrealistic expectations of foster carers has the potential of setting foster carers up to fail, places unreasonable demands on carers, and puts in place a veneer of assurances that the child is adequately safeguarded and carers are protected from allegations being made against them.

Finding 4: The established norm of seeking a commitment from male foster carer that they will not have unsupervised contact with a female child in their care to avoid allegations being made, provides a veneer of assurances that the child and carer are safeguarded.

Summary: A safe system needs to balance the need to protect vulnerable children from foster carers who may harm, and foster carers from false allegations of causing harm. There is no simple solution to this but a tokenistic response, such as highlighted in this finding, risks neither parties benefiting at all.

Issues for the Board and Individual Agencies

Fostering Panel

- The Safe Caring Family Policy that is included as part of the foster carer assessment pack to be reviewed by Panel members to ensure greater emphasis is placed on how the individual circumstances of a child are considered in safe caring arrangements and how carers will be supported.
- Panel to explore the intention behind the question posed to foster carers about how they will manage allegations made against them and re-consider what ( if any) questions are asked on this issue at panel.
- Panel to consider adopting any innovative practice that exists elsewhere on this issue.
- Panel to receive training from the LADO (or appropriately experienced trainer) on key findings from serious case reviews and research that has been conducted with adults who abuse their position of trust.
- Panel to consider what support can be offered to carers when they are caring for a child who has previously been the victim of sexual abuse.
- Fostering Panel learning and development plan to reflect the learning from this finding and issues to be taken forward.
- Fostering Panel to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.
### Children’s Social Care

- Fostering teams and assessing social workers to receive training from the LADO (or appropriately experienced trainer) on key findings from serious case reviews and work that has been conducted with adults who abuse their position of trust.
- Audit of fostering files to be conducted to review the extent to which this requirement has been stated as part of a fostering or placement agreement and to consider how this will be addressed.
- Fostering teams to explore what innovative practice exists elsewhere in relation to this issue.
- Learning and development plans for respective teams and for the service to reflect the learning from this finding and issues to be taken forward.
- CSC to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

### Issues for Croydon Safeguarding Children Board

- CSCB to decide where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress and to consider how challenge will be provided.
- CSCB to consider how this finding will be incorporated into the existing learning that has emerged from audit findings or case reviews in relation to how the role of fathers or male figures is understood and valued in the life of children.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.

### Finding 5: Management systems

There is an efficient placement allocation process for children in need of a placement that is managed through a business process. The absence of a practice based matching process at this early stage of placement risks decision making that compromises a child’s needs.

### Introduction

The process of matching a child’s needs to carers is understood to be the formal process of meetings and decision making, led by the Fostering Panel. This process applies to all children where a long term match is being considered; a similar practice based matching process for children entering care does not exist. When a child enters care and requires a placement, whether in an emergency or not, the decisions about where a child will be placed are made by referring to the Business Relationship Team (BRT), which is responsible for identifying a placement.
Although the term ‘matching’ is not used in relation to the initial placement of a child, it was not possible to identify any other process apart from the process of referral to the BRT that considered Claire’s needs and the suitability of Mr and Mrs George to meet these needs. It is a process where, for understandable reasons, resource pressures associated with availability of placement options and budgetary constraints play a significant part in deciding a child’s placement. The review team learnt that for perfectly rational reasons, relating to a desire to provide stability for a child and the absence of available foster placements from which to choose, the initial placement often becomes the long term placement for a child. Hence, although there was a challenge put to the lead reviewers that the term ‘matching’ only applies to decisions in relation to long term placements of children (where there is a clear practice based decision making process in place), because these initial placements often become the long term placement for a child, by default the initial decisions made through the BRT process are the critical matching decisions.

How did this feature in this case?

The care plan for Claire was long term fostering: she needed permanency within a family where she could develop a positive identity, form healthy attachments and where her needs would be understood and met. The history of multi-agency involvement with her birth mother clearly indicated that this permanency could not be achieved within the mother’s care. Adoption was ruled out because Claire was felt to be too old for permanency to be achieved in this way and there was a view that permanency could not be achieved in familial care. Consequently, a search for a foster placement commenced.

Identifying a suitable placement involved a referral to the Adolescent Resource Team (now known as ‘The Business Relationship Team’). This referral was made by the social worker, and later followed up with an email stating that due to Claire’s complex needs, a specialist foster placement may be needed. The BRT is made up of a staff team who are responsible for identifying resources for children in need of placements and the referral of Claire was considered by a member of the team. Their aim is to find placements quickly and effectively; cost is an understandable consideration and in-house foster carers are the placement of choice. It was identified that Mr and Mrs George had been recently approved as foster carers and were waiting to have a child placed in their care; they were approved to take a child of Claire’s age, lived in the local area, and were able to take and collect Claire from school. A member of the fostering team was briefly consulted, Claire was ‘matched’ to the placement and subsequently placed.

Claire was a young child with early trauma and complex needs: her behaviour in the care of her paternal grandmother, including spontaneous screaming for long periods, frequent agitation, and difficulties sleeping, indicated that she was suffering from the effects of significant early trauma. The review team attempted to understand how her needs were considered in matching her needs to these carers. This was not an emergency placement: Claire had been living within the care of the local authority for four months and she had been known to the local authority since birth. Apart from the referral sent to the BRT, it was not possible to identify any other paper work or practice based decision making processes where Claire’s needs were described in a way that would facilitate decisions on matching. Under the review timeline, Claire had not been in placement with Mr and Mrs George long enough for the routine practice based matching process to commence, as this normally commences a year after initial placement. However, in line with normal practice: It was assumed that if it went well with ‘Mr and Mrs George’ this would be a long term placement (practitioners and managers).
How do we know it is not unique to this case?

As stated above, the case group were clear: matching a child’s needs to carers does not take place through the referral to the BRT. Time and again it was said that this was a ‘business process’, governed by the resource constraints of budget and resource availability. Matching a child to carers takes place through a different ‘matching process’: this is a practice based process involving assessment and Panel approval. However, practitioners were also consistent in saying that if a child is in a placement longer than a year then this is considered as the long term placement for the child and that permanency decisions are based on how well the child settles in placement, and whether the carers are prepared to care for the child long term. Feedback from those involved in the formal matching process confirmed this position.

It was clear to the review team that there are two distinct processes in place in placement decision making, one that makes decisions about where a child should be placed based primarily on resource availability and cost, and one that is a practice based decision making process that matches a child to placement based on a child’s needs. There was a divergence of views amongst staff members from the different teams about where matching a child’s needs to carers takes place. Those practitioners who had experience of the practice based matching process were clear: the initial decision taken when a child is first placed with carers is in reality the fundamental matching decision. When speaking about the BRT process, social workers and their managers referred to this as a ‘matching process’; members of the BRT were equally clear: the referral to the BRT team is not a matching process.

It was demonstrated that this confusion generates frustration between the different staff teams: matching a child definitely causes tensions between the LAC social worker and everyone else involved. I have often got frustrated that people were putting resources rather than the child’s needs first (front line practitioner). And, in relation to what takes priority when placements are being sought: you have to take what you are given… there is no choice (case group member); it is pot luck what is the budget available, and what is available on the day (manager).

How widespread and prevalent is the issue?

In discussing this finding, members of the review team and case group drew on their experiences of working in numerous local authorities throughout their respective careers. They confirmed that although the extent of choice about placement options varied (according to different budgetary pressures, levels of demand for placements and availability of placements), their experiences suggested that the absence of a practice based matching process, in the early stages of placement, meant that the initial placement decision is significantly influenced by business considerations. Further, they commented that it is common for initial placements to become the long term placement for a child.

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20 Claire was in placement with Mr and Mrs George for 15 months, it was unclear why this formal matching process did not take place.
There is no national data available on how many children are affected by this pattern and there has been no specific data collected in Croydon that is relevant to this finding. Whilst it is acknowledged that it is possible that not all looked after children are affected by this pattern, it is equally accepted that a sizable number of children are potentially affected. The numbers of looked after children in Croydon are relevant: In 2014 there were 790\textsuperscript{21} looked after children in Croydon. Croydon has the highest number of looked after children across inner and outer London (the nearest local authority being Greenwich which, in 2014, had a population of 540 looked after children). In addition, it is relevant to note the significant pressures on local authorities to reduce spending, and placements are a high cost pressure: local authorities in England were looking after 68,110 children on 31 March 2013, and in 2012-13, authorities spent £2.5 billion on costs associated with children’s placements.

A report by The National Audit Office in 2014\textsuperscript{22} examining services provided to looked after children reported that \textit{Local authorities we visited base decisions on children’s placements on short-term affordability rather than long-term strategies to meet needs assessments.}

\textbf{What are the implications for the reliability of the multi-agency safeguarding system?}

Many looked after children have complex needs arising from their experience of abuse, neglect, separation and loss. Matching a child with a foster carer is one of the ‘turning points’\textsuperscript{23} in a child’s life. When decisions are made about where a child’s needs are best met and a decision about their placement is based on a rigorous practice based matching process that is not compromised by considerations of cost, this placement has the best potential of meeting their needs and supporting them to overcome previous trauma.

If this system is not working children may be placed with carers who do not have the skills or resources to meet their needs, and in these circumstances placements are likely to break down. Placement breakdowns can be devastating for children in care, replicating the trauma of their separation from their birth parents, giving rise to feelings of rejection and anger, and causing further damage to already insecure attachment patterns. Furthermore, placements that are not meeting a child’s needs are often a drain on local authority resources, preventing resources being used more creatively and effectively to improve outcomes for the child, and leading to social workers’ time and energy being focussed on managing short term problems and crises rather than on the long term best interests of the child.

\textsuperscript{21} Department for Education Statistics 2014  
\textsuperscript{22} Department for Education: Children in care, National Audit Office: 2014  
\textsuperscript{23} Schofield et al 2011: Care Planning for Permanence in Foster Care, University of East Anglia
**Finding 5:** There is an efficient placement allocation process for children in need of a placement that is managed through a business process. The absence of a practice based matching process at this early stage of placement risks decision making that compromises a child’s needs.

**Summary:** A safe system will promote decisions based on a clear understanding of children’s needs, and these needs will take priority in any decisions. Although resources are a consideration for all local authorities, if these are balanced by a strong focus on the needs of a child, and a commitment to investing in a child’s long term future, then this has the best potential to enable a child to grow up with consistent carers, establish secure attachments and flourish.

**Issues for the Board and Individual Agencies**

**Children’s Social Care**
- Matching a child through the BRT processes to be further examined to consider what changes may need to be made to allow the needs of child to be better considered when making placement decisions.
- For decisions that have to be made in an emergency, services to consider what opportunities are in place to fully scrutinise this match and consider any changes that need to be made (including what additional support may be required in the placement).
- For decisions that do not have to be made in an emergency, services to consider how a practice based matching process can be strengthened.
- Systems changes, including how the current ICS system and supervisory arrangements may need to be adapted to embed practice based decision making, to be explored.
- Learning and development plans for respective teams and for the service to reflect the learning from this finding and issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Designated governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

**Issues for Croydon Safeguarding Children Board**
- CSCB to consider where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.

The following two findings (6 & 7) are linked but they are presented separately because each finding raises distinct issues within safeguarding systems and, whilst they may well interrelate, they are of considerable importance in their own right.
Finding 6: Patterns of communication and collaboration in longer term work

When a child is looked after there is a shared assumption across the multi-agency network that the child is safe and that existing processes will provide adequate protection; this assumption is unsafe and leads to a lack of partnership working.

Introduction

In recent years, there has been understandable pressure to take a pragmatic approach to children who are the subject of a Child Protection Plan and who are looked after, the thinking being that a dual process (of a child being subject to a Child Protection Plan and to LAC Reviews) is not needed.

The practice reasoning behind this position is that existing processes in place for children who are looked after (such as the LAC Review process) is able to provide adequate safeguards. The London Child Protection Procedures published in 2010 and the revised version published in 2015, provides clarity on this issue:

*If a child subject of a child protection plan becomes looked after under s20, their legal situation is not permanently secure and the next child protection review conference should consider the child’s safety in the light of the possibility that the parent can simply request their removal from the local authority’s care. The child protection review conference must be sure that the looked after child care plan provides adequate security for the child and sufficiently reduces or eliminates the risk of significant harm identified by the initial child protection conference.*

This finding has shown that in Croydon, a blanket approach has been taken to removing the names of children from a Child Protection Plan who are looked after, on the assumption that existing processes for a child looked after will automatically ensure a child’s safety. This assumption is shared by the multi-agency network but it is an assumption that is unsafe.

How did this feature in this case?

Prior to Claire’s removal from the care of her birth mother, there had been an Initial Child Protection Case Conference at which she was made the subject of a Plan under the categories of neglect and sexual abuse. Subsequently, Claire was placed within the care of her paternal grandmother as a child in care. The Review Child Protection Case Conference that followed made a decision that, as Claire was in the care of the local authority, she was adequately safeguarded. Her Child Protection Plan was ended, and no further Conferences were held. This was despite information shared at the conference that Claire was in fact in care under a voluntary agreement: the local authority did not share parental responsibility with Claire’s birth mother (who was within her rights to return Claire to her care if she so wished). In addition, information shared at the Conference suggested that Claire may not be safe within this placement as there was a potential of Claire’s birth father (who was a Schedule One offender) having contact with her and there were concerns that this risk had not been adequately assessed.

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24 London Child Protection Procedures 2010
25 The types of offences against children or young person’s up to the age of 18 years, usually referred to as ‘Schedule 1 Offences’ are set out in Schedule 1 of the Children and Young Persons Act 1993. Briefly, they include: • All forms of child abuse; • Any form of sexual assault; • All other forms of maltreatment including murder, manslaughter, infanticide, incest, violence, neglect or cruelty.
Despite Case Conference members being aware of these potential risks and voicing concerns, there was no objection to the decision that she should no longer be the subject of a Child Protection Plan and no agencies took any action to follow up on the concerns they had voiced.26 There were no subsequent multi-agency forums in place that focussed on Claire’s safety.

How do we know it is not unique to this case?

Information provided during the follow on meetings with the case group suggested the assumption that children in the care of the local authority are safe is a commonly held assumption. Case group and review team members spoke about the difficulties in thinking the unthinkable. They spoke of a blindness about this issue and asked where do you draw the line? You have to assume safety somewhere otherwise how can you do the job.

Members of the case group spoke about the work involved in the two processes, which was felt to be repetitive, and about how, in order to comply with the demands imposed by the LAC Review and Child Protection Conference process, a considerable amount of form filling and report writing is required: this can add to the considerable pressure felt by front line multi-agency services in meeting the demands of their safeguarding role. Hence, an approach that ensures only one of these processes is involved at any one time, founded on an assumption that if a child is looked after they are, by the nature of being looked after, safe, has enabled a pragmatic approach to be taken to reduce work load and rationalise finite resources.

It was argued that in principle LAC Reviews, chaired by an Independent Reviewing Officer, should have a responsibility to take on this role for children who are looked after. Indeed this requirement is detailed in the London Child Protection Procedures. However, feedback from the case group and from the documentation reviewed revealed that in practice LAC Reviews are not a substitute for child protection case conferences: the focus of these meetings is not on protection; it is on care planning. Risk and safeguarding issues are not routinely discussed and the full multi-agency group is not included, as evidenced in this case. Hence, the assumption that the LAC Review process would be the forum for risk management and safety planning is an assumption that, in the experience of case group members, is not borne out in practice.

How widespread and prevalent is the issue?

It is now common practice to remove the name of a child from a child protection plan when they become looked after by the local authority or county council. It is a practice that has grown up and become commonplace across the county over the past few years. It is not known how different authorities have approached this issue, as no relevant research has been conducted and no data collected.

In March 2014 there were 790 looked after children in Croydon. In line with routine practice none of these children were the subject of Child Protection Plans and this remains the current position. There has been no local or national auditing or research examining the quality of LAC Reviews in relation to risk assessment and risk planning.

26 Subsequently, the lack of clarity about the risks posed by birth father, and the suspicion that he may have had contact with her, whilst in the care of paternal grandmother, was put forward as a possible reason as to how Claire may have contracted gonorrhoea and chlamydia, and influenced the decision to leave her in the care of Mr and Mrs George.
What are the implications for the reliability of the multi-agency safeguarding system?

A child is best protected when multi-agency processes, set up to prevent harm to a child, are operating well and (regardless of the child’s legal status, home environment or carers) there are no assumptions made that the child is ‘safe’. Multi-agency meetings, characterised by a clear child protection focus, robust sharing of information, and clear lines of communication throughout and across the respective organisations, are proven to safeguard children successfully. If multi-agency partners are not working in this kind of system, they may develop the dangerous assumption that a child is safe because he or she is looked after. With this approach comes the risk that the multi-agency network will not work in a way that is informed by a child protection focus or knowledge, information that seems to suggest that something is not right for the child will not be challenged and assumptions will be made. This approach is likely to lead to failures to respond when a child is at risk of significant harm, and does not recognise that looked after children deserve the same protection as all other children.
**Finding 6:** When a child is looked after there is a shared assumption across the multi-agency network that the child is safe and that existing processes will provide adequate protection; this assumption is unsafe and leads to a lack of partnership working.

**Summary:** In the challenging work of safeguarding children and protecting them from harm, making any assumptions poses a risk to a child’s safety. When a child is looked after by the local authority and when concerns remain about the safety of that child, to assume that the child is safe, or to assume that other existing processes will effectively take the place of established child protection multi-agency working, poses a risk.

**Issues for the Board and Individual Agencies**

**All relevant agencies**

- Agencies to review how challenge is effectively raised about the safety of children, with particular reference to this practice in child protection case conferences.
- Agencies to explore how practice in this area will be strengthened.
- Agencies to put in place an internal (agency specific) process that embeds challenge as an accepted responsibility of respective agency practice in safeguarding children.
- Agencies to consider how they will contribute to information sharing, risk assessment and decision making, when a child is looked after.
- Agencies to consider any systems changes that may be needed to embed practice (including but not exclusive to: supervisory arrangements, recording practices and changes to databases).
- Learning and development plans for respective agencies to reflect the learning from this finding and issues to be taken forward.
- Respective agencies to identify an internal governance body or designated lead responsible for maintaining an overview of planned actions, changes that have been made, and the impact of these changes.
- Designated lead or governance body to be accountable to CSCB and keep CSCB updated of progress.

**Looked after Reviews and Child Protection Conferences**

- Relevant service areas to examine how these planning processes link together, so, where needed, responsible chairs and IROs share information and integrate relevant processes.
- LAC Review documentation, including the agenda of the Review and minutes of the meeting to be reviewed to explore how a strengthened focus on safeguarding will be achieved (including discussion of risk and planning for a child’s protection).
- Responsible service area to explore further how multi-agency representatives will be consulted with, and involved in decision making and planning, in safeguarding looked after children.
- Relevant heads of service to review how child protection chairs and IROs provide effective challenge to practitioners and to partner agencies in safeguarding children and how effective escalation is achieved.
- Systems changes to be explored, including how the current ICS system and supervisory arrangements may need to be adapted to embed changes in practice.
- Learning and development plans for respective teams and for the service to reflect the learning from this finding and issues to be taken forward.
• Responsible service areas to report to the internal designated governance body on planned actions, changes that have been made, and the impact of these changes.
• Internal governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

Issues for Croydon Safeguarding Children Board

- Is CSCB satisfied that the blanket approach of removing the name of a looked after child from a Child Protection Plan is justifiable in all cases? Could there be exceptions to this rule when risks remain?
- How will CSCB be satisfied that the LAC Review process will effectively involve multi-agency partners and manage risks?
- How can CSCB assist in strengthening a culture of challenge and debate across agencies in safeguarding children? Are the current escalation processes robust and how does the board know whether they are used routinely and effectively?
- CSCB to consider how they will be kept informed of progress by partner agencies and consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.

Finding 7: Patterns of multi-agency working in response to incidents and crises

When a child is looked after the value of multi-agency strategy meetings/discussions and the crucial part played by professional challenge is not understood; this inhibits effective multi-agency safeguarding work and leaves children vulnerable.

Introduction

In line with primary legislation (Section 47 of the Children Act 1989) and procedural guidelines27, multi-agency strategy discussions and meetings are required to take place in response to concerns that a child is in need of protection. The purpose of these discussions or meetings is to share information and to make multi-agency decisions about the steps that need to be taken to protect a child from harm. It has been argued that, in this case, safeguarding action was taken, and indeed it was, but there is a distinct difference between safeguarding action and child protection action: safeguarding action can apply to a wide range of steps taken to safeguard a child from harm and to promote good outcomes across a range of areas in a child’s life; the action taken in Claire’s case was not a child protection response and was not in line with procedural requirements. As a result, Claire was not adequately protected.

How did this feature in this case?

In order to demonstrate the seriousness of this finding a number of examples are given.

The first example relates to concerns raised by Claire’s school. At this time, Claire was looked after by the local authority and was placed in the care of her paternal grandmother. The social work team allocated to Claire at the time was the Child in Need Team, as her case had not yet been transferred to the LAC Team. After spending her first overnight stay with Mr and Mrs George, as part of a planned introduction to her new placement, Claire arrived at school the next day. It was noticed that she was walking with her legs splayed open throughout the school day: this behaviour was not characteristic of Claire; she had never walked in this way before. When asked why she was walking in this way, Claire told her learning assistant that she hurt inside and when asked about what this meant, she demonstrated with her hands and told her teaching assistant that she was hurting inside her vagina. School staff were very concerned, and after they had had discussions with the Deputy Head (Safeguarding Lead), the Deputy Head called CSC to express their concerns. Later in the day, the social worker contacted the Deputy Head and reported: I have consulted with management in relation to the information you have disclosed, as Claire has not identified or directed the disclosure at any person in particular we will not be referring the information to the police. No investigation followed and no strategy meeting was held. School staff did not take any action to escalate this matter to ensure a multi-agency strategy meeting took place.

A second example occurred several months later. For some time Mrs George had noticed that Claire had a thick vaginal discharge; she tried treating the discharge with cream bought from the local pharmacy but without success, so she contacted the GP. At the request of the GP, Claire was brought to the surgery by Mrs George. On examination, the GP identified that the skin around Claire’s vagina was red and inflamed and observed a prurient green discharge pouring out of her vagina. The opinion of the GP was that Claire had a sexually transmitted infection; gonorrhoea was suspected and swabs were taken. The GP was aware that the disease attacks the pelvic organs and can result in infertility; she was very concerned and was keen for immediate action to be taken. The concerns were shared with the social worker and with the social worker’s line manager. After a discussion with the LADO (a staff member responsible for managing allegations against staff) a decision was taken by CSC to wait for the swab results; no child protection action was taken.

Five days later, the results from the swabs showed that Claire had gonorrhoea and chlamydia. The GP contacted the LAC social worker, who immediately consulted with a senior manager. The social worker was told to visit Claire in her placement, to inform Mr and Mrs George and to talk to Claire. A number of actions were taken that could arguably be regarded as safeguarding action, but no child protection action was taken on this day and no multi-agency partners were consulted. Claire remained in placement until the following day.
How do we know it is not unique to this case?

When the conversations were held with the multi-agency practitioners, and when the ‘View from the Tunnel’ was shared with the case group, there was a very strong reaction to this issue. Case group members were taken aback by the lack of child protection action taken: for many it provoked an emotional response evoking feelings of rage and blame, and for many there was just a sense of feeling overwhelmed and of deep despondency. Various suggestions to account for why things happened the way they did were put forward and tested. The first suggestion that was tested was whether the underlying issues outlined in finding 6, were the nub of the issue. Whilst it was felt this may have had a part to play, it was concluded this was not the central underlying pattern.

As the conversations with case group members continued, it was found that at the heart of the issue was this finding. Information gathered pointed to a lack of clarity about the purpose and value of strategy meetings; this was demonstrated in the decisions taken in response to the three incidents described above involving a range of managers within the local authority, the lack of successful multi-agency challenge of these decisions, and the subsequent lack of multi-agency involvement in the action that was taken.

During the conversations held with front line practitioners and their managers within the multi-agency network, it became clear that a shared understanding of the intrinsic value of multi-agency strategy meetings was not embedded, nor was the responsibility of multi-agency partners to provide effective challenge. In addition, there seemed to be a mind-set about strategy meetings in relation to looked after children that influenced decision making – you would have to take the position that the local authority was in some way responsible for the harm suffered as they are in the parenting role – and this was felt to be an uncomfortable position to take.

How widespread and prevalent is the issue?

Research by the NSPCC recognises that when a child is looked after, this can impact on the decision making by professionals in relation to concerns about the care they are receiving: Communication and information sharing between agencies was not always sufficient.

The media have widely reported on cases involving the sexual abuse of children (many of whom have included children who are looked after) where the necessary multi-agency child protection investigation and action has not taken place; these cases do not have to be repeated here. Research focussing on the response to children who are looked after and who are victims of sexual exploitation, suggests there is a reluctance to instigate child protection procedures in the form of multi-agency strategy meetings, as the intrinsic value of these multi-agency forums in assessing risk and planning a strategy of intervention for these children is not realised.

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28 View from the Tunnel: Multi-agency perspectives drawn from conversations with case group members (held as part of the SCIE LT Case Review Model).
29 Keeping Children Safe: NSPCC 2014
30 What’s Going On? Jago, Arocha et al University of Bedfordshire 2011
Local data shows that the number of strategy discussions taking place during 2011-2012, in respect to looked after children, represented 10.68% of the overall number of strategy discussions held. A similar percentage is seen in the years 2012-2013 and 2013-2014. No detailed interrogation of this data has taken place and so it is difficult to draw firm conclusions however, given the high number of looked after children in Croydon and the particular vulnerabilities of this group, this figure seems relatively low. The review team were unable to source relevant local multi-agency data in relation to this issue.

**What are the implications for the reliability of the multi-agency safeguarding system?**

Strategy meetings are the bedrock of multi-agency safeguarding practice, where assessments, assumptions and judgements made by individual professionals can be tested and developed, the responsibility for planning and risk management can be shared, and an accountable plan developed to investigate concerns and to protect the child.

A safe system is characterised by professionals who value strategy meetings and are clear when and why strategy meetings are held, and understand the important contribution they are required to make regardless of whether or not a child is looked after. Understanding what to expect of partner agencies, and taking robust action to challenge and escalate concerns, forms part of the child protection responsibilities expected of all agencies and if used to good effect creates a healthy child protection system.

If the value of strategy meetings, as a forum with legislative powers to share information and expertise and to coordinate a multi-agency child protection response, is not understood, the section 47 process will be drained of its power to protect children. If professionals fail to challenge each other in this complex work, it is likely that an ineffective, reactive, muddled, single agency response will be provided to address situations of serious risk. This leaves an unfair and dangerous level of responsibility in the hands of social workers, who will be investigating these risky situations without a coherent plan informed by multi-agency expertise, and without full knowledge of the child’s circumstances. This can lead to children remaining in unsafe situations, and evidence which may need to be used in a criminal investigation being contaminated, individuals who pose a risk to children may go undetected and may continue to cause harm.
Finding 7: When a child is looked after the value of multi-agency strategy meetings/discussions and the crucial part played by professional challenge is not understood; this inhibits effective multi-agency safeguarding work and leaves children vulnerable.

Summary: Understanding the value of information sharing and decision making within a formal multi-agency strategy meeting/discussion is critical if children, regardless of whether or not they are looked after, are to be protected from harm. In order for this to work safely and effectively, multi-agency challenge and escalation must form part and parcel of the everyday work. If these components are not culturally embedded within safeguarding systems, the protection of children will be compromised.

Issues for Croydon Safeguarding Children Board

The issues raised in respect to how agencies promote challenge within their respective organisations are represented in the finding above and are relevant to this finding. The issues in this finding are of such urgency that the issues set out are for consideration by the Board in the first instance:

- How will CSCB be informed of the training and tools that may be needed by the multi-agency workforce to develop knowledge and expertise in relation to the requirements of section 47 of the Children Act 1989, and to strengthen the ability of professionals to respond effectively when they are concerned about a child’s safety?
- Does a training programme need to be developed to specifically support social workers practising in Looked After teams to continually improve their knowledge of the assessment of risk and the conduct of section 47 investigations?
- How can a culture that encourages discussion and challenge in safeguarding children be fostered throughout organisations and what would such a culture look like? Do changes in the relationship between agencies, departments and teams, need to take place to facilitate this?
- How does CSCB and individuals in positions of responsibility and authority, effectively demonstrate a healthy attitude towards debate and professional challenge?
- How is the expertise of designated safeguarding professionals, and those in the role of quality assurance such as CP chairs and the LADO, embedded in safeguarding decision making?
- How will CSCB members evidence how the lessons learnt are integrated into the learning and development plans of partner agencies?
- How will CSCB be kept informed of progress by partner agencies, and how will progress be evaluated and challenge provided?
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.
Finding 8: Patterns of communication and collaboration in longer term work

Multi-agency partners are not sufficiently engaged in supporting the local authority to make decisions about the care of a looked after child. This impacts on how the local authority is able to fulfil its parental responsibilities when meeting a looked after child’s needs.

Introduction

In line with all relevant legislation\(^\text{31}\), when a child becomes looked after by the local authority under a Care Order, as set out in The Children Act 1989, the local authority holds parental responsibility for the child. Parental responsibility is defined in the Act as: all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property. In terms of duties: The local authority has a duty to safeguard and promote the welfare of the children in its care. The child, parents and other relevant people should be consulted in the decision-making process regarding a child being taken into care and during their time under local authority care.

This finding suggests that in practice the interpretation of the term ‘relevant people’ does not include the involvement of multi-agency partners, and that formal partnerships are not in place in a way that holds sufficient weight or meaning in how decisions are made about the care of a looked after child.

How did this feature in this case?

Claire was a child with complex needs; she had been the subject of a Child Protection Plan for the duration of her early childhood and was again the subject of significant harm when she was 6 years old. She had experienced multiple early trauma that included long term neglect, exposure to domestic violence, and sexual abuse. As a looked after child, she was the subject of multiple assessments completed by partners across a range of agencies and services. One of these assessments included a LAC Medical. Completion of this medical is a basic requirement for all children who are looked after; this medical was over 4 weeks late. There were several health needs identified in this assessment that required prompt follow up; apart from sending this assessment to the LAC social worker nothing else was done by the designated health professional to ensure Claire’s health needs were met. A significant number of multi-agency assessments were dutifully provided to the social worker, but none of the partners made any attempt to be actively involved in decision making and none of the many care planning meetings held by the local authority involved multi-agency partners. Claire had such complex needs that her care required the active involvement of the respective specialists to ensure her needs were met. This did not happen and instead her care was left solely in the hands of the local authority.

\(^31\) Children Act 1989 and 2004
How do we know it is not unique to this case?

During case group meetings involving practitioners and managers from across the multi-agency network, there was a very clear position taken by those representing the local authority and articulated by case group members in the following ways:

I think most professionals understand they have a role to play in a looked after child’s life but they don’t see themselves in a parenting role like the social worker does, or see this as part of their professional identity (frontline practitioner).

….. I think other professionals often try to avoid playing a role in managing or carrying decision making for children who are looked after and see this as the social worker’s job (front line practitioner).

Multi-agency practitioners gave examples of when they were not included in decision making or consulted with sufficiently in relation to children who are looked after with whom they are involved, but equally spoke about being unable to prioritise attendance at meetings where the planning for these children takes place. Examining what may lie beneath this lack of prioritisation revealed that if a child is living at home as part of a Child Protection Plan their case is prioritised above that of a looked after child. This thinking is based on the notion that the remit for involvement in professional decision making about a child living at home was clear, whereas the rights professionals have to be involved in making a contribution to decisions about the care of a looked after child was less clear.

Members of the case group representing a range of agencies, services and disciplines, understood the strategic commitment held at a senior level to this joint working, were aware of guidance and knew of some initiatives within their own agencies that focussed on meeting the needs of looked after children. However, it was clear that these initiatives were often agency specific, and integration of the strategic commitment to share the responsibilities for improving outcomes for looked after children is not integrated into the day to day delivery of services.

How widespread and prevalent is the issue?

Over recent years, there have been a number of initiatives to improve partnership working in relation to Looked After Children. Generally, these initiatives have focussed on two specific areas of a child’s development (education and health): there are long standing quality assurance measures in place in relation to these areas of a child’s life but, aside from these measures, there is no quantitative data available (locally or nationally) that interrogates the true nature of the partnership working that takes place for looked after children. These issues are explored in the recent Croydon IRO Report submitted to CSCB in July 2015. Whilst no data is presented about this issue, the report makes helpful reference to the aspirations of the IRO service in relation to how partners can be joined in parenting a looked after child:

The writing of this report has provided an opportunity to reflect on the IRO service delivery, outcomes for Looked After Children and the responsibilities of Corporate Parents. The Children’s Act 1989 Guidance and Regulations states:
the role of the corporate parent is to act as the best possible parent for each child they look after and to advocate on his/her behalf to secure the best possible outcomes. The guidance goes further and states; however, they cannot fulfil this responsibility without the full co-operation and support of a range of other agencies which provide services to children and their families. ....
...As Corporate parents we are obliged to be the best we can be...We must be committed to our Looked after Children achieving to their full potential. In order to do that, we must be willing to have difficult conversations, commitment appropriate resources and hold each other accountable.

What are the implications for the reliability of the multi-agency safeguarding system?

Many looked after children have complex emotional and behavioural needs and need support from a large network of professionals. If this network is working effectively, information about the child can be shared and multi-agency expertise used to develop the child’s care plan, with each member of the network understanding how their work contributes to the overall plan. Clear and reliable lines of communication between everyone in the network and a collaborative and supportive attitude towards taking a responsibility for promoting positive outcomes allows the complex task of parenting a looked after child to take place, and increases the likelihood that a child will achieve their potential.

If the network is not engaged in making decisions about a child, professionals will be working in isolation, professional knowledge and expertise will not be shared, potential risks may be missed, and the chances of the network being able to safeguard and support the child in reaching their potential will be reduced. There is also a risk that individuals will be working towards different goals, and professional disagreements or differences of opinion will not be resolved, leading to splits in the network. Children are likely to pick up on these splits, which may cause them anxiety and confusion and a sense that the adults in their lives cannot help them. This approach is unlikely to improve outcomes for looked after children.
Finding 8: Multi-agency partners are not sufficiently engaged in supporting the local authority to make decisions about the care of a looked after child. This impacts on how the local authority is able to fulfil its parental responsibilities when meeting a looked after child’s needs.

Summary: Legislation, statutory guidance and procedure, outline the responsibilities of local authorities and partners in the care of children who are looked after. Ensuring the correct balance between the leadership role of the local authority and the other responsibilities shared by partners is a challenge. At a strategic level, multi-agency ambitions for looked after children are shared, but, as this case has shown, there are challenges on the front line in achieving these ambitions in practice in the lives of individual children.

Issues for the Board and Individual Agencies

Health (including mental health services) and Education

- Agencies to review how they currently contribute to care planning meetings (including looked after reviews), and examine whether the quality of this contribution is sufficient.
- Agencies to identify obstacles that may inhibit this contribution, and identify what could be put in place to improve practice in this area.
- Agencies to review whether members of staff are aware of the responsibilities they hold in relation to looked after children, and identify possible changes that could be made within the organisation to facilitate better engagement.
- Learning and development plans for respective agencies and services to reflect the learning from this finding and the issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Respective internal governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

Children's Social Care (including Looked after Reviews)

- Services or teams to identify any current obstacles that may be inhibiting effective partnerships with agencies or other professionals, when planning for a child’s needs.
- Relevant service areas to examine how the different roles of the social worker and carer(s) complement each other in achieving effective partnerships with involved agencies. Good practice to be identified and used to assist service wide learning and development.
- Responsible services to review how agencies are kept informed of planned changes for a child, and whether existing processes and planning meetings need to be adapted to facilitate the involvement of partner agencies.
- Audit to be conducted looking at the effectiveness of LAC Reviews in achieving multi-agency engagement and consultation, including how the minutes and outcomes of LAC Reviews are shared with agencies. Any areas of improvement to be identified and to form part of an improvement plan for this service area.
- Systems changes to be explored, including how the current ICS system, meeting formats and supervisory arrangements, may need to be adapted to embed changes in practice and processes.
- Learning and development plans for respective teams and for the relevant service areas to reflect the learning from this finding and issues to be taken forward.
Finding 9: Patterns of communication and collaboration in longer term work.

There is pattern of social workers and managers representing different teams within the local authority LAC service working in relative isolation. This has a negative impact on the way in which looked after children are safeguarded and affects how their needs are met.

Introduction

Established primary and secondary legislation, guidance and regulations\textsuperscript{32} dictate the different responsibilities of the local authority in meeting the needs of looked after children; local authorities have responded structurally to these regulations by establishing various teams which, in line with these regulations, hold responsibility to provide specific services to children who are looked after. The two teams that have regular direct contact with the child and with foster carers are the LAC social worker team, which holds responsibilities in relation to the child, and the Fostering social work team, which hold responsibilities for providing support to foster carers. The teams are overseen by the same senior line manager but are divided according to their respective roles and responsibilities and so report to different line managers within a specific service area. On an operational basis, there are differences in their job descriptions, supervisory arrangements, and targets and performance indicators; furthermore, the teams are often located separately. Whilst this has, understandably, been put in place by local authorities to ensure that all duties are properly carried out, unless systems are in place to promote a unity in the work, this relative isolation risks compromising a joint approach to meeting the needs of looked after children.

\textsuperscript{32} Including but not exclusive to: Children Act 1989, Children and Young People’s Act 2008, associated guidance and regulations
How did this feature in this case?

During the timeline under review it was difficult to find occasions when Claire’s social worker and the social worker from the Fostering Team met together, visited the family together, or attended the same meetings. This limited communication and lack of joint working led to a number of occasions when important information known to one social worker was not known to the other. The following are two illustrations:

At the Fostering Panel, and later at the pre-placement planning meeting, Mr George gave assurances that he would not be alone when caring for Claire. The documents containing this information were placed on the local authority fostering database, but Claire’s social worker did not have access to the fostering file, as this was held in a separate database. There were no discussions between the two social workers about this agreement with Mr George, no meetings were held when they were both present and where this information could have been shared, and so Claire’s social worker was unaware of this requirement.

The day after Claire’s placement with Mr and Mrs George, Mrs George contacted the Fostering Service. She told the fostering social worker: *I do not want this child*, and asked for Claire to be immediately removed from the home. In the recording on the fostering data base it was stated: *she does not want to go home to face Claire* and that: *she has not eaten or slept for four days* (since Claire had an introductory overnight stay with the carers). The fostering social worker consulted with her manager and visited the carers the next day. She noticed that: *Mrs George looks drawn and she has lost weight... She looked like she had been crying... as soon as she is faced with Claire she becomes tearful... she says that she looks at Claire and feels guilty*. This information was placed on the fostering database but it was not shared with Claire’s social worker. This meant that Claire’s social worker was not given an opportunity to consider the meaning of these statements or what impact this might be having on Claire; as a result, Claire’s wellbeing was not properly considered.

Throughout Claire’s placement with Mr and Mrs George (one year and three months), apart from the visit made at the end of the placement when the swab results were confirmed, there were no meetings or visits that included the fostering social worker and Claire’s social worker. In addition, the separate nature of the databases, the different information recorded in these databases, and the fact that Claire’s social worker could not access either database, meant that important information was not considered. This has a negative impact on how Claire’s needs were thought about and met.

How do we know it is not unique to this case?

During discussions with the case group and during conversations with social workers and their managers from different teams, it became clear that this was not particular to Claire’s case. Whilst there were examples given of fostering and looked after social workers working together well, it was apparent that the key to successful joint working was as a result of the individual relationship between specific workers representing the different teams, not as a result of the opportunities inherent within existing structures, systems, or processes. As a result, joint working is variable and largely characterised by work that takes place in parallel rather than in unity. Case members spoke about how their different roles and responsibilities lead to separate meetings, and about how information and case recordings about the foster carers and the child are kept in separate databases.
It was generally agreed that due to the limits of recording, and a confusion about what information should be stored where, social workers and their managers could not rely on the information they had access to within the different databases to comprehensively inform their work with children and carers.

The review team heard about many internal meetings held as part of planning and decision making processes for looked after children (such as LAC Reviews and Permanency Planning Meetings), and a number of other meetings held by fostering teams. It is commonplace for these meetings to involve only one social worker (either the looked after social worker or the fostering social worker). A member of the review team advised that: *there are no structural obstacles to this joint working*, and reported that there have been a number of initiatives (such as joint training) to facilitate this relationship. However, evidence from the various documents seen in this case and from information gathered during the conversations held with a range of practitioners representing the LAC social work teams and the fostering teams, it was clear that in practice this joint working is not embedded.

**How widespread and prevalent is the issue?**

Due to the complexities of fulfilling the duties of a corporate parent, through necessity all local authorities split the parenting role and associated tasks, placing these roles and tasks into different areas of responsibility and into different processes. Different workers in different teams with different roles and responsibilities undertake this parenting role, and distinct processes allow the completion of parenting tasks.

Although there is no research on this issue, experience suggests that this is commonplace across the country. There is no local or national data or research examining how these teams work together to fulfil the parenting role.

**What are the implications for the reliability of the multi-agency safeguarding system?**

Children placed in foster care need to be looked after within a family that is able to offer love, nurture, stability and containment. Providing this kind of care to children who may have complex emotional and behavioural needs, is a challenging and emotionally demanding job. Two key professionals who are in close contact with the child and family are the child’s social worker and the foster carer’s supervising social worker. In a system that is working well, together these professionals will hold the history of the child and the family in mind, have regular joint contact with the child and the carer(s) and frequent communication, thereby providing a strong support network and a unified approach in meeting the child’s needs and supporting the carers to meet these needs. Establishing such a relationship nurtures a mutual understanding that the two professionals share the job of promoting the safety and well-being of the child, whose needs lie at the heart of the work they are doing. This collaboration allows observations and concerns about the care the child is receiving, and about any challenges or stressors that the foster carer may be facing, to be identified, shared, and promptly addressed in a way that is supportive to the carer and is focused on the wellbeing of the child.

If the two workers are working in isolation and important information is not shared, a child’s needs risk being unmet and concerns about the standard of care that the child is receiving may be missed. In addition, if carers are struggling with the complexities of their caring role and a lack of unity is sensed between the workers, this is likely to compound their difficulties, can threaten the safety and stability of the child’s placement, and can result in the child’s needs being compromised.
Finding 9: There is pattern of social workers and managers representing different teams within the local authority LAC service working in relative isolation. This has a negative impact on the way in which looked after children are safeguarded and affects how their needs are met.

Summary: Various local authority teams are in place to carry out the corporate parenting duties bestowed on local authorities and county councils by legislation and guidance. This means that there can be numerous teams involved directly or indirectly with a looked after child. If systems and processes are in place that promote integration and unity, these structural separations should not prevent these teams from work well together in the best interests of the child. However, if there are limited organisational opportunities to embed this approach, if there is disunity in relationships or if the various processes and systems are not fully integrated, work will take place in parallel and a consistent joint approach to meeting the needs of children and carers is unlikely to happen. This will have a negative impact on how children safeguarded and how their needs met.

Issues for the Board and Individual Agencies

Children’s Social Care

- Heads of service to explore the current relationship between the social work teams, examining any systemic organisational factors that may be having a detrimental impact on this relationship.
- Heads of service to identify examples of good practice and to examine what factors are in place that facilitates this relationship. Learning to be shared across the services to promote improvements.
- Services to examine current meetings in place across the LAC and Fostering teams, establishing which of these meetings must involve both social workers, and taking steps to improve this area of work.
- Heads of service to review current guidance on this joint working and to make any necessary changes (including any changes to existing supervisory arrangements) to promote this joint working.
- Current data storage systems to be reviewed; any required changes to recording and access to be made and clarity to be provided on how information should be recorded and shared.
- Systems changes to be explored, including how the current ICS system, meeting formats, and supervisory arrangements may need to be adapted to embed changes in practice.
- Learning and development plans for respective teams and for the service to reflect the learning from this finding and issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Internal governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.
Issues for Croydon Safeguarding Children Board

- CSCB to consider where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how the Board will be best informed of progress and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.

Finding 10: Management systems

The importance placed on performance indicators has led to a pattern whereby the Independent Reviewing Officer (IRO) Regulations take second place to these indicators; this compromises the role of the IRO and the quality of care planning.

Introduction

The Independent Reviewing Officer’s Handbook33 (IRO Handbook), and related regulations34 and procedures35, provide the statutory guidance for IROs and local authorities in relation to the case management and review of the care provided to looked after children.

There are two clear and separate aspects to the function of the IRO: chairing the child’s review and monitoring the child’s case on an ongoing basis. In exercising both parts of this role, the IRO Handbook outlines the responsibilities of the IRO in relation to a wide range of areas including, but not exclusive to: Facilitating consultation with a wide range of parties, promoting the voice of the child; ensuring that plans for looked after children are based on a detailed and informed assessment, are up to date, effective and provide a real and genuine response to each child’s needs.

And: Offering a safeguard to prevent any ‘drift’ in care planning and as part of the monitoring function IROs have a legal requirement to monitor the local authority’s performance in respect of reviews.

The intention is to enable the IRO to have an effective independent oversight of the child’s case, and ensure that the child’s interests are protected throughout the care planning process.

For a number of years, the way in which local authorities have been judged in relation to their capacity to meet the needs of looked after children has been predicated on the performance data local authorities have provided to government. This data remains an important part of the inspection regime. As a result, these indicators have become an established part of the routine quality assurance reporting mechanisms within local authorities.

33 IRO Handbook Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children DCSF
34 Care Planning, Placement and Case Review (England) Regulations 2010 and the accompanying statutory guidance Putting Care into Practice
Distinct data recording processes are in place to collect the data and to report on this data, and this work remains very much part of the organisational culture. All local authority staff who are working with looked after children are well aware of their responsibilities in relation to meeting performance indicators: these indicators often form part and parcel of supervision and target setting. However, there are no such quality assurance indicators in place that measure the quality of LAC Reviews in line with the IRO regulations. Measuring compliance with these regulations is down to the discretion of the local area and/or the individual IRO. In times of high volume, or when the system is under pressure, it is the established performance indicators that take precedence. This can lead to the unique role of the IRO being compromised, and this has an impact on the quality of care provided to looked after children.

How did this feature in this case?

Claire’s initial review was held at the social worker’s office, and was attended only by the social worker and the IRO. No consultation took place with paternal grandmother, Claire, or multi-agency partners. The minutes are a descriptive account of events leading to Claire’s placement in care. Recommendations are a statement of position; some relate to tasks that needed to happen; these tasks related only to health appointments that needed to be actioned by the paternal grandmother: *Grandmother will make an appointment with the dentist and optician* and *Grandmother will ensure that any other health appointment are kept*. The minutes of the meeting were not received by the paternal grandmother and so it is unclear whether she was aware of these tasks but the record of the review demonstrated that, in theory, the associated performance indicators were covered. In line with the core regulations and statutory guidance, the critical questions that needed to be asked at the Review related to the care plan for Claire. The plan articulated was that Claire would remain in long term fostering in the care of her paternal grandmother; the question of achieving permanency planning for Claire under relevant legal orders was not discussed.

At the second review, Claire was still living within the care of her paternal grandmother, the review should have taken place in Claire’s home with her grandmother but the review was held at the home of Mr and Mrs George. The venue and membership of the meeting was contrary to existing guidance, the permanent plan for Claire was not discussed, and the procedural duties laid out in the child protection procedures, in relation to risk management and safety planning, were not considered. However, there were clear recommendations made in relation to Claire’s dental checks, her personal education plan and her health assessment, all of which are directly linked to existing performance indicators.

How do we know it is not unique to this case?

Discussions with the case group about the purpose of LAC Reviews in the life of a looked after child revealed a general sense of lethargy about these meetings. There seemed to be no investment in these reviews as a process that improved outcomes for children. They were felt to be just ‘an added thing that needed to be done’; to be ticked off in a long list of process requirements that hampered rather than helped the busy life of a front line social work team. Case group members spoke about LAC Reviews being focussed on process rather than practice: *LAC Reviews are 100% about process*. This view was shared by a number of front line social workers and their managers.
In wider discussions with the multi-agency group, the perspective of partners evidenced a clear confusion over the purpose of a LAC Review and, on further discussion, many professionals struggled to see themselves as having a role or responsibility in relation to these meetings. From the perspective of the various teams within the local authority, there was a sense of ambivalence about the value of LAC Reviews and the role of the IRO. From the perspective of the IRO, there was a strong sense that the IROs were working in a sausage factory, where quality was not valued (only keeping to process); ensuring reviews were held on time and that performance indicators were covered were felt to be the key quality measures that are prioritised: No one cares…… not even Ofsted…… all they are interested in is the PI’s, there is no systematic interrogation of quality, there are no PI’s on quality and no audits on compliance with IRO regulations” (CSC manager). An IRO case load is in excess of the guidance and this drives IRO’s down a process led by the Performance Indicators” (CSC manager).

How widespread and prevalent is the issue?

IROs were introduced on a statutory basis in 2004, and the Care Matters Green Paper consultation in 2006-2007 provided an opportunity to take stock of the new role. The key issues to emerge were that IROs were not sufficiently robust in challenging decisions made by local authorities, even in cases where professional practice was obviously poor and not in the interests of the child. Not every statutory review was being conducted in a way that encouraged a challenging analysis of the proposals for meeting the child’s needs, and insufficient weight was given to the views of the child, to those of his or her parents or carers, and to other professionals with a role in securing his or her welfare:

Unless care plans are rigorously examined the review is no longer an opportunity for informed reflection on the child’s progress and planning for the child’s future; instead it becomes merely a sterile ‘box ticking’ exercise.

The changes to legislation, supported by changes to the IRO guidance, were made with the intention of taking forward the Government’s commitment to secure significant improvements in the contribution IROs can make to improving care planning and securing better outcomes for looked after children. These changes are yet to be evaluated by Government, although it is noteworthy that research in 2014\(^36\) conducted by the National Children’s Bureau states:

It is 10 years since IROs were created in response to widespread concern about children in care being lost to sight. Yet the key conclusion of this study is that the IRO role in ensuring high-quality care planning is still to be fully realised. The report is full of examples of what can be achieved by a well-organised service, but it also uncovers the widespread problems that still exist.

The requirement that all looked after children must have regular reviews of their care led by an IRO means that during 2014-15, 802 children in Croydon were the subject of regular LAC Reviews. In terms of the wider population, the UK figure is 93,000. It is not known how many children are the subject of poor quality Reviews that have an overriding focus on the timeliness of the process and targets linked to performance indicators, but the research above suggests this group may well be significant.

\(^{36}\) The role of Independent Reviewing Officers (IROs) in England: Final report Helena Jelicic, Ivana La Valle and Di Hart, with Lisa Holmes from the Centre for Child and Family Research, Loughborough University National Children’s Bureau: working with children, for children.
In Croydon, in line with IRO regulations, an IRO report was submitted to CSCB in July 2015. This report outlines the work of the IROs with the current population of 802 Looked after Children. Within this report, it is clear that the quality assurance measurements for LAC Reviews relate only to the timeliness of reviews, completion of health related action, and the educational performance of looked after children; there are no quality assurance measures or audits in relation to compliance with the IRO regulations. The report makes the following comments:

For too long there has been an over emphasis on [the role of the IRO] in relation to compliance and performance timescales. Whilst recognising the importance of a timely response to the needs of children and families, the IRO quality assurance role needs to be more focussed on the quality of the work undertaken by Children Social Care and partner agencies as part of the Looked after Children review process.37

What are the implications for the reliability of the multi-agency safeguarding system?

LAC Reviews provide a mechanism for reviewing how effectively children’s care plans are meeting their needs, for addressing poor planning or drift, and for identifying any safeguarding action that needs to be taken. When LAC Reviews are working effectively, the IRO will hold a thorough understanding of the child’s needs and journey through care. The IRO will chair a meeting informed by a process of consultation with the child and with those who know the child best, and will bring the child’s network together to identify whether or not the child’s care plan is working, whether the child is adequately safeguarded, and the actions that need to take place to address any gaps. In a system that is working well, IROs make a significant contribution to service wide quality assurance, effectively confronting systemic poor practice and challenging the local authority where drift or delay in care planning exists, or where a child is at risk of harm.

If the IRO is constrained by a need to keep rigidly to existing performance indicators, or is constrained by the need to keep to process or to a tick boxing exercise as an overriding priority, the IRO will not have a comprehensive understanding of the child’s needs or a motivation to make a real, challenging, creative contribution to the child’s life, and the safety net that the Review process should provide for children will not exist. In this system, it is likely that gaps in children’s care plans will go unaddressed, drift will occur, and false reassurance will be given that the child is safe and desired outcomes are being reached because statutory tasks have been completed and performance indicators met.

37 Croydon Annual Reviewing Officer Report 2014-2015
Finding 10: The importance placed on performance indicators has led to a pattern whereby the Independent Reviewing Officer (IRO) regulations take second place to these indicators. This compromises the role of the IRO and the quality of care planning.

Summary: Independent Reviewing Officers occupy a unique place in the work of a local authority, holding a critical responsibility to take an independent overview of the care a looked after child is receiving, to take action to ensure a child’s needs are met, and to hold the local authority to account (if necessary through court action). Over the years, a narrow focus on a handful of performance indicators has had a significant impact on the LAC Review process and resulted in diluting the core functions of the IRO in the life of the child. As a result, the potential for IROs to make a significant contribution to children’s care plans, and to service wide quality assurance and development, has not been sufficiently realised.

Issues for the Board and Individual Agencies

Children’s Social Care – Looked after Reviews

- Do current performance indicators in place that measure the quality of LAC Reviews need to be revisited and revised in light of this finding?
- How is compliance with the IRO handbook, and associated regulations, reviewed and quality assured?
- What are the mechanisms in place for IROs to challenge care planning and to take steps to achieve any required improvements?
- Is there anything within the organisational culture that inhibits the IRO in championing the needs of a child and in making a significant contribution to care planning?
- How are LAC Reviews regarded within the wider service? Is it felt that LAC Reviews make a significant contribution to how children’s needs are met, or have they become largely an administrative exercise that brings no extra value to an already overburdened system?
- Systems changes to be explored, including how the current ICS system, meeting formats and supervisory arrangements, may need to be adapted to embed changes in practice.
- Learning and development plans for respective teams within the service to reflect the learning from this finding, and issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Internal governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

Issues for Croydon Safeguarding Children Board

- How does CSCB propose to respond to the recent IRO report received by the Board?
- CSCB to consider where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress, and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.
Finding 11: Patterns of communication and collaboration in longer term work

When a child is looked after, the principle that family members can make a valuable contribution to a child’s care and protection is understood but not fully realised. This has an impact on the quality of care and protection provided to children.

Introduction

Preserving children’s links with their birth families, valuing these relationships and the contribution that family members can make to decision making, planning and interventions, can strengthen the way in which a child is safeguarded and positive outcomes achieved. The involvement of family members in the lives of looked after children has been the subject of extensive research and training and is well covered in legislation\(^{38}\) and associated guidance. The principles behind this are therefore well understood. This case has shown that translating these principles into practice is more difficult, and this results in the potential benefits of involving family members in the care and protection of a child being missed.

How did this feature in this case?

When the lead reviewers met with Claire’s paternal grandmother and paternal aunt, they were shown a photograph album. In this album were photographs depicting Claire’s life story: photographs showing her time spent with extended family members on her birthdays and holidays, and her relationships with significant members of her kinship. The occasions depicted were numerous. It was clear her paternal grandmother and aunt knew her well: they knew her likes and dislikes, her favourite things, her fears, her sadness and her joy. They held her life story in these photographs, and in their shared memories. For the duration of Claire’s care within the local authority during the time under review, there was only minimal consultation with paternal grandmother and paternal aunt about Claire’s needs, and little involvement in care planning. Their knowledge and memories of Claire were not sought, and so professionals never had the benefit of learning from this.

When Claire was placed with Mr and Mrs George, Claire stayed with her paternal grandmother every other weekend, in order to provide ‘respite’ to the carers. As a result, both the paternal grandmother and paternal aunt held information that was critical in understanding Claire’s experiences in the care of Mr and Mrs George.

For example; they spoke about Mr George being very active in the care of Claire, and of occasions when he was alone in the home when they returned Claire after a weekend. They had important details to share in relation to the discharge they observed when she was in their care, and about the accounts given by Mrs George in respect to the diagnosis and treatment she claimed Claire was receiving, which were in fact untrue. There was no attempt to seek any information from the paternal grandmother about these issues, and it was only after she was spoken to as part of this review that this information was revealed.

\(^{38}\) The Children Act 1989
How do we know it is not unique to this case?

When the review team spoke to the case group during conversations and case group meetings, it was clear they understood the theoretical basis underpinning why such a contribution is so important. However, for many this contribution was seen as being established only through ensuring contact arrangements were set up and reviewed.

As the review team dug deeper into this issue, it was difficult to find information to show how family members were supported to make a significant contribution to a child’s life in a way that informed assessments, care planning and decision making. A number of reasons were put forward as to why this might be the case: these reasons indicated how responsibility for enabling this significant contribution fell, in practice, to the child’s social worker. This is time-consuming work, and is often negatively impacted by what was felt to be an adversarial relationship between the local authority and family members (particularly where care proceedings have taken place). In addition, case group members spoke about how complicated it can be to negotiate meaningful contact with birth family members, and to ensure that this happens in practice. They spoke about the complicated emotional responses of some children to contact, and of foster carers sometimes ‘getting in the way’ of sustaining this lifelong connection.

In terms of seeking information from relatives to inform a child protection investigation, this was an area that seemed to be fraught with obstacles. Many of these obstacles posed very real complications that were difficult to unpick and get round. Case group members spoke about family members who may have a vested interest in providing biased information, and how the constraints in relation to data protection and confidentiality, and fears about information sharing, can cause confusion. This can have an impact on how family members are meaningfully involved in risk assessments and decision making in the life of a looked after child.

In relation to how information held by family members is used to assist work with a looked after child to promote an understanding of their life story and identity, there was a view that this information is sought, but it seemed to the reviewers that this was often only when a life story book or life story work was being completed with a child. It was not seen as information that could be collected dynamically and used frequently, in a professional’s day to day work with a child.

How widespread and prevalent is the issue?

Research and literature39 in this area is well established. The Care Inquiry, 201340 (literature review of research into permanency options for children) comments on the critical nature of nurturing the meaningful connection of children with birth family members. This inquiry cites research and literature evidencing the need for this meaningful connection, and the paucity of this connection in the lives of children looked after away from familial care.

In terms of gathering, and placing importance, on the information held by family members research suggests that: Insufficient weight is given to information from family, friends and neighbours and that: there is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.41

There are no relevant local audits or any data available on this issue.

39 To name a few: Keeping in touch” (A report of children’s experience by the Children’s Rights Director for England 2009. Children and Young People’s Views on Being in Care A Literature Review Hadley Centre for Adoption and Foster Care Studies Coram Voice 2015

40 Understanding permanence for looked after children: A review of research for the Care Inquiry Janet Boddy

41 Ten pitfalls and how to avoid them. What research tells us? Dr Karen Broadhurst, Professor Sue White, Dr Sheila Fish, Professor Eileen Munro, Kay Fletcher and Helen Lincoln NSPCC September 2010
What are the implications for the reliability of the multi-agency safeguarding system?

In a system that is working well birth family members are enabled to make a valuable contribution to the lives of children placed in care, supporting children who may have little or no contact with their birth parents to retain links with their family of origin, and giving professionals information about the child’s story which might otherwise be lost. This is then used to inform assessments and in the day to day work with a child, assisting professionals and carers to understand the child’s needs and supporting children to develop a coherent and positive sense of their own identity. Birth family members who are meaningfully engaged often provide practical support to care leavers, reducing their vulnerability as they enter adulthood and their network of professional support falls away. In making use of this support, organisations foster a culture of valuing family members and including them in planning for the child, wherever this is safe and appropriate for the child; inviting birth family members to LAC Reviews, involving them in assessments and life story work, and supporting them to have the right level of contact with the child.

In an organisation where the important contribution of the kinship network is not appreciated, children are likely to be seen outside of the context of their birth families, there will be a narrow focus on supporting them through professional intervention alone and significant information that could strengthen how a child is safeguarded will be lost. Key pieces of information or artefacts which would be familiar to children living within their birth families may not be preserved and relationships which could sustain children for years to come will not flourish.

Finding 11: When a child is looked after, the principle that family members can make a valuable contribution to a child’s care and protection is understood but not fully realised. This has an impact on the quality of care and protection provided to children.

Summary: The importance of family members and kinship in the life of a looked after child is well known. However, if this does not translate in practice to work that meaningfully involves family members and kinship in assessments, care planning and protection, the care provided to children by professionals will not be sufficiently informed and the immediate and long term outcomes for a child will be compromised.

Issues for all agencies

- Agencies to explore whether there are any cultural attitudes, beliefs or organisational obstacles that inhibit how family members are facilitated in making a contribution to the assessment of risk and care planning.
- Agencies to consider how they might assist in making improvements in this area.
- Relevant agencies who have regular contact with family members (such as schools) to consider how information provided by family members can be usefully shared.
- Where there is an absence of family involvement, supervision to provide challenge, and explore reasons for this absence.
Issues for Children’s Social Care (including Looked after Reviews)

- Services to explore whether there are any cultural attitudes, beliefs or organisational obstacles that inhibit how family members are facilitated in making a contribution to the assessment of risk and care planning.
- Services to explore the role of the IRO and child protection chair in this area, and examine how LAC Reviews and CP Conferences could be adapted to strengthen the contribution of family members, and establish how engagement in a child’s life can be achieved wider than the confines of contact arrangements.
- Risk assessments to include information from family members, and to provide clear evidence to support why information either has not been sought or should be treated with caution.
- Services to explore how current meetings can better facilitate the involvement of family members and include the knowledge they hold about a child.
- Services to explore how life story work is completed and take steps to facilitate the dynamic nature of information gathering about a child’s life and family (that is not confined solely to the completion of a life story book) so that information is sought, and information shared with a child as part of an ongoing process of strengthening a child’s sense of identity.
- Systems changes to be explored, including how the current ICS system, meeting formats and supervisory arrangements, may need to be adapted to embed changes in practice.
- Learning and development plans for respective teams within the service to reflect the learning from this finding and issues to be taken forward.
- Responsible service areas to report to the designated internal governance body on planned actions, changes that have been made, and the impact of these changes.
- Internal governance body to report to CSCB on planned actions, changes that have been made, and the impact of these changes.

Issues for Croydon Safeguarding Children Board

- CSCB to consider where accountability will be held for maintaining detailed monitoring and evaluation of the learning and development.
- CSCB to consider how they will be best informed of progress and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.

Additional Learning

This additional learning is not presented as a finding as it was not possible to uncover the systemic reasons that may lie behind the issues. That said, the importance of this learning should not be underestimated. It is strongly recommended that it should part of the future work of the Board and relevant agencies, to identify what needs to happen to achieve improvements in this area.

Management guidance and use of authority

Throughout the review the review team were struck by the number of front line staff who were relatively inexperienced, and were undertaking a piece of work in the case for the first time. These front line practitioners were critical, they included the CIN social worker, the LAC social worker,
Claire’s Teaching Assistant, the assessing Fostering social worker, and the GP. This was a complex case, and the delivery of services on behalf of their agencies was in their hands. These practitioners understood the gravity of the work they were doing, and the need to ‘get it right,’ and so they all appropriately sought advice and guidance from managers and service leads.

For a number of these practitioners, the advice and guidance they received at critical points in the case, was unhelpful, and for some of them, the advice they received was misguided, this placed practitioners in very difficult, and on occasions compromised, positions and had a direct impact on how Claire was safeguarded. Overall, management guidance appeared to be characterised by decisions based on the ‘here and now’. There was little evidence of reflective supervision, or of a form of supervision that supported the workers to manage the emotional cost of the work.

Importantly when managers, including on some occasions senior members of staff, were directly involved in the case, or were made aware of concerns about the decisions that had been taken by their partner agencies, despite some significant energy and commitment being put into attempting to resolve the issues by partner agencies, multi-agency challenge was ineffective. The CSCB escalation policy was not clear at the time, and this mitigated against a satisfactory conclusion being reached. It is understood that sufficient clarity has now been provided and this is helpful.

On occasions, as the appraisal of practice has shown, the limits of appropriate management guidance was relevant to a number of services, and applicable to managers across the management hierarchy throughout the time under review.

Several reasons were suggested as to why this might be the case, these included:

- Lack of an accepted culture of challenge and debate across the multi-agency network, and a poor understanding of the procedural duties of all professionals to provide robust challenge.
- Under developed practice in the provision of reflective supervision.
- Volume of the work, leading to a culture where poor practice is tolerated.
- Composition of the workforce within CSC (where a significant number of front line practitioners are newly qualified, thereby requiring additional management support).
- Fear of challenge, and a lack of understanding about the intrinsic value of challenge to children and colleagues in safeguarding work.
- Lack of relevant experience and training.

### Issues for Croydon Safeguarding Children Board

- CSCB to review existing and previous serious case reviews to examine whether the issues identified are systemic.
- CSCB to consider where accountability will be held for maintaining detailed monitoring and evaluation of any learning and development identified.
- CSCB to consider how they will be best informed of any improvements needed and progress made, and to consider how challenge will be provided.
- Findings and planned improvements to be integrated into the CSCB Learning and Development Plan.
Conclusions

As a child with an early history of abuse and trauma, who received services as a child in need, a child in need of protection and a child looked after, Claire is not unique. Many children who are known to multiple agencies have needs such as Claire’s, and many practitioners and managers across agencies and systems are involved in delivering a service to these children. This means that there is a complex and interrelated web of systems and individuals dealing with complex problems and providing multiple services to individuals and families, who all have their own unique needs.

There is no shortage of legislation, guidance, procedures, policies and protocols governing how agencies and services should work together to safeguard children and promote positive outcomes. Complicated processes are in place to support and assist this complex, challenging work.

A crucial health check of any organisation is to understand how existing cultures, processes and practices help or hinder service delivery at the front line. CSCB has undertaken this systems review in an attempt to understand multi-agency service delivery from the perspective of Claire, and the front line practitioner. It has been a long review and it has not been easy; the information that has emerged, and the findings that have been reached, have evoked many emotions, the work has been immensely time consuming for all involved. CSCB are committed to take forward the learning from this review.
Appendix One: Glossary

ABE: Achieving Best Evidence (police led interview with a child)
ART: Adolescent Resource Team
BRT: Business Relationship Team
CAFCASS: Children and Family Court Advisory and Support Service
CAMHS: Child and Adolescent Mental Health Services
CIN: Child in Need
CSC: Children’s Social Care (local authority social work teams)
CP: Child Protection
CSCB: Croydon Safeguarding Children Board
DCS: Director of Children’s Services
EPO: Emergency Protection Order (made under section 44 of the Children Act 1989; an Order conferring limited parental responsibility on the applicant, to allow a child to be protected in a place of safety on a short term basis)
IMR: Independent Management Review
IRO: Independent Reviewing Officer
LAC: Looked after child
LAC social worker: a looked after child’s allocated social worker
LADO: Local Authority Designated officer (responsible for the management of allegations against staff who employed within the children’s workforce)
LAC Review: Looked After Child Review meeting
LT: Learning Together
SCIE: Social Care Institute for Excellence
Section 47: Section 47 of the Children Act 1989 (the duty to carry out a child protection investigation to investigate the possibility that a child may be suffering or have suffered significant harm)
Section 20: Section 20 of the Children Act 1989 (the provision for a child to be voluntarily placed by his or her parents in accommodation provided by the local authority; in this instance, parental responsibility remains with the parents and is not shared by the local authority)
Supervising social worker: a foster carer’s social worker
TA: Teaching assistant
TM: Team manager