



## Child Safeguarding Practice Review (CSPR) Part One

### Sexual abuse of children living outside of their birth families – Marie

Agreed by the Warwickshire Safeguarding Partnership in 2021<sup>1</sup>

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## 1 Introduction

1.1 The Warwickshire Safeguarding Children Partnership agreed to undertake a Local Child Safeguarding Practice Review (CSPR) to consider the sexual abuse of children living outside of the birth families. This was due to two unrelated children making allegations of sexual abuse, and the Partnership recognising that lessons could be learned about the way that agencies work together to safeguard children in care, or otherwise placed outside of their family, from sexual abuse in Warwickshire.

1.2 Learning has been identified in this review regarding:

- Recognising abuse and neglect of children in care
- The importance of relationships with professionals for children living outside of their birth families
- Understanding a child's lived experience and that behaviour is communication
- Identifying, understanding and responding to adult behaviours that might indicate they pose a sexual risk to children
- Challenging poor care from foster carers, and recognising neglect
- Responding to a child when they make an allegation of sexual abuse

<sup>1</sup> ADDITION 2025 - The significant delay in publishing this CSPR is due to the original report being thematic with the consideration of a second child who made allegations of sexual abuse from her carer. As the criminal investigation into this matter is severely delayed, the decision was made in 2025 to publish the learning from just Marie.

- 1.3 This report will focus on one of the children, who we will refer to as Marie<sup>2</sup>.

## 2 Process

- 2.1 An independent lead reviewer was commissioned<sup>3</sup> in 2020 to work alongside a panel of local professionals which met on a regular basis to undertake the review. Agency Information Reports (AIRs) were requested and received. These provided in-depth analysis and identification of single agency learning by all involved partner agencies with both children considered. Despite the impact of COVID 19, professionals involved at the time were meaningfully involved in discussions about each child and were consulted about practice more generally.
- 2.2 Marie was spoken to in 2021 as the criminal investigation had concluded in respect of her foster carer, with him receiving a significant custodial sentence. The lead reviewer and accompanying officer of the safeguarding partnership thank her for her insightful reflections at a difficult time.
- 2.3 This report has been written with the intention that it will be published and only contains the relevant information about the child's circumstances that is required to identify the learning.

## 3 The child

- 3.1 Marie is a fifteen-year-old child in the care of Warwickshire County Council who lived with foster carers in a neighbouring county, along with her younger sibling. The children had been in care since 2010 due to long term neglect in their birth family. They were placed with the foster carers in question after an adoption breakdown in 2013.
- 3.2 In 2020 allegations were made by an adult who used to be fostered by the family that they had seen Marie being sexually abused by the male carer. Marie later made allegations to professionals of long-term sexual abuse from the carer. This review has also identified long term neglect, particularly of the sibling, from the foster carers.
- 3.3 Marie and her sibling are white British. The foster carers are white British.

## 4 Learning and analysis

- 4.1 The review has identified learning gained from; the information shared during the Rapid Reviews; in the AIRs; during the consultations with professionals involved at the time; and when speaking to Marie. This learning is outlined below followed by the explanatory analysis.

Learning point 1: Children who are in care can remain at risk of abuse and neglect and be abused in these situations. Their history makes them more vulnerable to abuse.

- 4.2 It is reasonable to expect that children who have been removed from abusive or neglectful home situations will be safe and cared for when in the care system. Children who are being 'looked after' need to be protected and nurtured, and while this is usually the case in foster care, it isn't always so. Research shows<sup>4</sup> that moves and transitions, non-biological family relationships, and the children's earlier experiences of abuse, may increase the risk of child sexual abuse.
- 4.3 Marie's placement was seen at the time as relatively stable, and it was the plan that her and her sibling would remain with their foster carers for the rest of their childhoods. However, there was evidence of concerns about the quality of care prior to the allegations of sexual abuse being made. It is also apparent now that other children placed with the carers in the past are likely to have experienced abuse in the placement<sup>5</sup>. The known concerns were in relation to the attitude of the carers, their often-difficult relationships with professionals, the standards of care not always

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<sup>2</sup> The child chose this name.

<sup>3</sup> Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of CSPRs and is entirely independent of the WSP

<sup>4</sup> The Prevalence of Child Sexual Abuse in Out-of-Home Care: A Comparison Between Abuse in Residential and in Foster Care. Saskia Euser et al (2010)

<sup>5</sup> Police and social workers have spoken to all of those who were placed with the carers previously, and several other allegations were investigated and charges brought.

being what was expected and examples of them having and voicing negative views of the children.

- 4.4 There had been no concerns about the carers previously in relation to sexual abuse, but issues that could be determined as neglect of Marie and her sibling were present. The police investigation into the sexual abuse allegations has led to additional concerns of this type being shared by Marie and her sibling and by those placed there previously. The NSPCC, Action for Children and Research in Practice investigated the potential relationship between neglect and child sexual abuse<sup>6</sup>. The evidence suggests that the impact of neglect can ‘interact with other factors and adversities in a number of ways to increase young people’s vulnerability to harm.’ This includes vulnerability to sexual abuse. They suggest that practitioners working with children and families where neglect is a concern should ‘sensitively investigate the potential for co-occurring and cumulative forms of harm.’ So, when concerns emerge about either physical or emotional neglect within a child’s home, including their home with a substitute carer, on-going consideration should be given to the possibility that sexual abuse may also be an issue.
- 4.5 Research by York University and the NSPCC in 2014 considered local authority records on abuse in care placements. They concluded that while most foster carers do an excellent job in often difficult circumstances, most abuse or neglect of children in foster care is perpetrated by the carers. They found that there are between 450–550 confirmed<sup>7</sup> cases of different types of abuse or neglect in foster care across the UK each year<sup>8</sup> and that around 11 per cent of this abuse is sexual. The Independent Inquiry into Child Sexual Abuse reminded us in 2017 that children who experience sexual abuse may suffer from life-long consequences, such as mental health issues, substance misuse, offending, unstable future relationships, and being vulnerable to further sexual abuse or other types of abuse. So being aware of the possibility of sexual abuse in care is important providing children in care with the best possible life chances.
- 4.6 While any child can potentially experience sexual abuse, some are likely to be more at risk, and they include children who have experienced other forms of abuse<sup>9</sup>. Marie and her sibling were neglected in their birth family. They had many placement breakdowns, including an adoption breakdown and one where Marie later said they had been physically abused by a foster carer. All children in care are likely to be vulnerable, so professionals need to be alert to the possibility of sexual abuse and be able to ‘think the unthinkable’ about carers who they may know well and who they may work closely with.

**Learning point 2: Children at risk, particularly those not living with their birth families, need to have significant relationships with a professional if abuse or neglect is to be identified.**

- 4.7 The review found that Marie had numerous changes of professionals in the two years before the abuse was disclosed. Marie shared her frustration and said to the review ‘how can I express myself when I don’t know my social worker and there’s no relationship or trust? I have had so many different social workers, and they don’t seem to know anything about my life’. Her experience is reflected nationally and more widely. In January 2020 the NSPCC published a short report<sup>10</sup> which summarises the learning from published case reviews about child sexual abuse. The case reviews considered show that professionals should ‘take the time to build a consistent, stable and long-term relationship with the child. This includes talking to children away

<sup>6</sup> Elly Hanson, Debbie Allnock and Simon Hackett (2016)

<sup>7</sup> These findings are likely to underestimate the true extent of the problem, as over half of the unsubstantiated allegations could not be proven one way or the other.

<sup>8</sup> The figures were taken from referrals to the LADO (Local Authority Designated Officer) in respect of carers, to ensure they did not include abuse of children in foster care outside of the home.

<sup>9</sup> Finkelhor, Ormrod, and Turner, 2007

<sup>10</sup> Child sexual abuse: learning from case reviews - Summary of risk factors and learning for improved practice around child sexual abuse. NSPCC January 2020

from parents and carers and fostering an environment where children feel safe to talk.’ Children in care often experience multiple changes of professionals, including their social workers, Independent Reviewing Officers (IRO) and those providing therapeutic interventions.

- 4.8 Relationships with professionals were not straightforward for Marie and her sibling. This was partly due to the length of time they were in care and general staff turnover, and then the foster carers moved house in 2018. Organisational issues also had an impact, as in Warwickshire when a child in care reaches the age of 14, they transfer to the social work team for children in care, which was another change of social worker for Marie following the house move out of Warwickshire. An unrelated decision was also made to allocate a new IRO due to the workload of the previous IRO.
- 4.9 Moving school part of the way through secondary school can have an impact on a child’s education as well as on relationships with staff and peers. The social work records state that Marie did not initially want to change schools and that she needed support with this transition. At the time there was a decline in her behaviour and an incident of self-harming. While Marie was later said to see the move as an opportunity for a fresh start, there were also losses and changes to manage. There was a focus in the child in care review held prior to the move that stated the carers may need more support with the children due to the move. The AIR pointed out that the focus appears to have been on the carers at this time rather than the children. As this case shows, supporting carers should not deflect from a need to also focus on the child and consider more holistically what may be unsettling them.
- 4.10 It is known that a child is unlikely to make an allegation of sexual abuse, particularly when the perpetrator lives with them. NSPCC data suggests that seven years is the average time from start of sexual abuse to disclosure for those that do disclose<sup>11</sup>. All professionals need to be alert to the possibility of abuse in foster placements, but they also need to be aware that a child is unlikely to make a disclosure of sexual abuse, even when they have a good relationship with professionals working with them. In Marie’s case there was an unexpected witness who shared what they had seen and what had previously happened to them.
- 4.11 Even when a disclosure is made, professionals should consider that it may only be a partial disclosure, and the child may under-disclose to test out the response and reaction to what is said. An abused child is likely to have complicated feelings about disclosing<sup>12</sup> due to their relationship with the abuser and the grooming that has occurred, and from fear of what a new placement may hold. Marie was seen as having a close bond to the male carer who was so often ‘on her side’ and felt to be a strong advocate for her. This type of confusing and difficult dynamic means that there will be losses and potential guilt when considering making an allegation. For the same reasons it is also common for victims of child sexual abuse to recant their allegations.
- 4.12 As well as ensuring that children in care or previously in care have a professional they can talk to and have access to when required, a NSPCC and University of York 2014 study<sup>13</sup> stated that ‘visiting children, listening carefully to what they say and spending some time with them away from placements are of fundamental importance’ as is communication and information sharing between agencies. It is evident that there were concerns about the carers, although there is no evidence that any professional was concerned about the risk of sexual abuse. The professionals who know the children and the carers well have been shocked and saddened by the allegations.

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<sup>11</sup> ‘No one noticed no one heard’ 2013

<sup>12</sup> In this report reference will be made on occasion to the children ‘disclosing’. This is because they are believed by the professionals involved. The review is aware of the dialogue about the use of language by professionals who work with children. It is noted that the alleged perpetrators have not yet been found guilty of abuse in court.

<http://www.transparencyproject.org.uk/why-words-matter-the-debate-about-disclosure/>

<sup>13</sup> Nina Biehal, Linda Cusworth, Jim Wade with Susan Clarke 2014

- 4.13 There was a lot of involvement from professionals with Marie and her sibling, many of whom worked hard to build relationships and spend time with the children both within and out of the placement. They had allocated social workers throughout the placement and there was a mixed picture regarding the relationships they had with them. Looking back there does appear to be a pattern of Marie not responding positively to social work visits in the home, and the foster carers intervening to try and apologise and explain away her behaviour. Alongside this however, there was also several occasions where the male foster carer (who was described as the dominant personality in the home) was extremely rude to professionals. He was also very critical about Marie's sibling, who tended to be the focus of concerns. The carer's complaints focused on services received in the past, and professionals struggled to get him to move forward and plan for the future in a positive way. This was mostly played out in front of the children and arguably would have made it harder for Marie and her sibling to build a positive relationship with the professionals, as they were likely to receive a negative view of services from the carers more generally. Marie said, 'he was always telling us not to trust the professionals, and they gave me no reason to trust them based on my own experience'.
- 4.14 Both Marie and her sibling received therapeutic support, and the handover of this at the time of the house move was handled well. The sibling had physical health and learning issues which made them particularly vulnerable. Prior to the house move their school had shared some concerns about the child's care, including their physical appearance and the carers not communicating with the school regarding the concerns. The sibling's new school also had concerns following the move, including about the carers lack of cooperation with the school and attitude towards the sibling. The police investigation following the allegations has indicated that there was on-going neglect and emotional abuse of Marie's sibling by the carers.
- 4.15 Those providing support to the sibling were concerned about the response of the carers to their health and emotional needs and worked hard to engage with the carers to improve things. There was some very good multi-agency practice from the social worker, the consultant paediatrician and other health staff to ensure that Child 2's sibling's needs were met, and challenge of the carers regarding their lack of cooperation with advice and changes to the child's medication levels. The concerns were not seen as enough to consider ending the placement, despite what was clearly a high degree of concern from those involved about the quality of care.

Learning Point 3: Professionals need to explore and understand a child's lived experience and what they may be communicating by their behaviour.

- 4.16 Listening to the 'voice of the child' has emerged as key learning in recent reviews,<sup>14</sup> as has the importance of recognising behaviour as a means of communication. Understanding the lived experience of a child is a complex process and the importance of professionals having a child centred approach is well recognised. As well as giving children access to a professional they can talk to, it is essential to consider a child's behaviour to identify what they may be communicating without words. This is particularly the case where children are behaving in a concerning way, such as self-harming or abusing substances. The 2020 NSPCC report states that 'if professionals are not continually challenging and curious about the source of a child's distress, this can lead to missed opportunities to recognise and stop sexual abuse'. It is known that over half of the children who report sexual abuse have some mental health issues such as anxiety or depression. Many also exhibit angry or self-destructive behaviours. Professionals need to be alert to this, even when other explanations could account for the behaviour (such as the previous trauma of early childhood abuse or neglect.) The behaviour of the young people needs to be viewed

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<sup>14</sup> The voice of the child: learning lessons from serious case reviews. Ofsted 2010

through the lens of their history and experiences, including having an open mind to what may be happening at the time.

- 4.17 Marie's mental health was a concern for those involved at the time. This included self-harm and overdoses. Marie's difficult early years, the placement breakdowns, and external issues such as bullying offered understandable explanations for her behaviour. Marie's school had reported possible cannabis use and concerns about on-line behaviour, which the carers stated was the reason for her negative behaviour in and out of the placement. This was not challenged, as it appeared plausible and was confirmed by the child when she was spoken to. There was a need for professionals to be more curious about Marie's behaviours. She said to the review "me ending up in hospital with an overdose should have been a trigger for concern, professionals should have wondered and asked me why I was trying to take my own life".
- 4.18 In 2018 and 2019 Marie was seen five times at the GP surgery with her male foster carer for non-specific abdominal pain, urinary tract infections and vaginitis (a condition which can be caused a number of issues such as chemicals found in toiletries or poor hygiene but can also be exacerbated by sexual abuse) and she was prescribed the contraceptive pill, seemingly at the request of the carer. There was no rationale recorded for this prescription. On another occasion the female carer spoke to the GP about Marie's aggressive behaviour, resulting in a referral to CAMHS. The AIR states that the GP appears to have accepted that, as foster carers, they were acting in Marie's best interests. This is an example of professionals needing to ensure that issues are not considered in isolation.
- 4.19 If there are reports that a child's behaviour may be indicating distress and there is also a health issue that could identify sexual abuse, it warrants further exploration and the need to build a holistic view of the child's lived experience. Best practice would have been to give an opportunity for the child to speak to the GP alone, even if that necessitated making a further appt. Children need to be provided with different ways to enable their voice to be heard, and professionals need to critically reflect on what is said and what children may be trying to communicate by their behaviour. Understanding the lived experience of the child is central to protective safeguarding work, as is allowing them time to speak alone with professionals without their parents or carers present.
- 4.20 The foster carers were described as strict, rigid in their thinking and it was known that they were not 'warm' with the children. A phrase used was that they were 'old school' and there was a view that they would be unlikely to be accepted as foster carers if they were assessed nowadays. The review asked if these issues were compatible with being foster carers. Arguably it would be if the carers received support, acknowledged they had made mistakes and wanted to learn, and if they were willing to work openly and in partnership with the professionals in the best interests of the children they care for.
- 4.21 Marie did not always want to meet with her social worker and was reluctant to accept the therapeutic support available to her. Professionals must be proactive when encouraging children in care to meet with them and should explore and record why children may refuse to meet with them 1-1. These refusals or avoidances should be monitored, considered as an indicator that the child may be concerned about the meetings, and that the influence of the carers may be having an impact. When speaking to the review, Marie said that she wished that professionals had created a space to meet with her outside of the home. She said 'he was always controlling the conversation just in case I disclosed anything to anyone about what he was doing to me. He was always there, even in hospital beside my bed when I came round from my overdose. Why didn't anyone tell him to leave the room? I can't understand why nobody did that for me. When I met with CAMHS they were more interested in asking me about my past but not really asking about what might be happening to me now and why I was trying to overdose all the time".

Learning point 4: Understanding and identifying adult behaviour that might indicate a risk to children.

- 4.22 As well as considering the behaviour of the child, it is important that professionals also consider the behaviour of the adults. This includes knowing about any concerns during previous placements. With the benefit of hindsight, it can be seen that the perpetrating carer displayed behaviours that are common 'grooming' techniques. The purpose of grooming is to reduce the likelihood of detection or the child disclosing and reducing the chance of the child being believed if they do disclose. As well as grooming children, perpetrators also groom and manipulate the adults around the child and the professionals involved. Perpetrators can be charming, or they may intimidate and frighten professionals so that they are distracted from abusive behaviours. It is complex work, and it is very difficult for professionals to understand what is happening in a family environment.
- 4.23 Grooming behaviours can be very subtle. They include favouritism within a family of a particular child, buying the child gifts and making the child depend on them. This type of behaviour was shown by the male carer towards Marie. He was known to buy her expensive perfume which the social worker recorded as positive at the time, as it led to the child feeling appreciated and valued by him. Perpetrators can also be controlling of their victims. The carer was very keen to take away access to her mobile phone when there were issues regarding Marie's use of social media. This was seen by the school at the time as positive and firm parenting. As this control of her mobile phone use happened at the start of the pandemic and when all teenagers could not have daily access to their friends, his response was punitive and rigid, and after two months and no flexibility despite challenge from the social worker, a placement stability meeting was held. This type of behaviour from the carer was not unusual, but it did not alert professionals to anything wrong beyond his style of parenting needing to be challenged. Marie addressed this with the review and said that she hoped that professionals would recognise how controlling her carer was. She said, 'I wasn't allowed to have my phone, I couldn't go out alone as he had to be with me all the time, I wasn't allowed to make any friends or have hobbies, and I didn't even get to celebrate my birthdays.'
- 4.24 Professionals involved did not necessarily think that the close relationship between the male carer and Marie was particularly odd. They were aware that the female carer appeared to be close to the sibling. They explained during the review that many families have father/daughter and mother/son preferences or closer bonds. It emerged following the allegations that both Marie and her sibling often spent time separately sleeping at the workplace of their male carer. This was not known to any professional at the time. Marie had told teachers she spent time at work with her 'dad', but this was not thought to be of concern or unusual. They told the review that they were not aware this involved night shifts, which they reflected may have concerned them. Marie's understanding and memory of this was different, she told the review that 'my school should have picked up on me always falling asleep in class, as I was always getting told off. I told my teacher that I was being taken out to work every night by him and that I would sleep on the floor. It wasn't followed up, so what was the point of me telling'.
- 4.25 None of the professionals working with either the children or the carers were fully aware of the full history of the carers that was held by the fostering team. Since the allegations, information has been found that might have been helpful to those responsible for supporting the children. The social worker for Marie and her sibling worked hard to engage with the children and communicated well with all those involved. She shared during the review that while she made sure to read all about the children's history when she was first became Marie's worker, she did not consider reading the history of the carers. All present agreed that this is not common practice. The circumstances of these children however show that knowing about previous placements can help to understand how best to support and challenge carers and can provide information on

what the risks might be. Although there were no allegations about sexual abuse made prior to those made leading to this review, there were other concerns evident and a history of difficult behaviour from the foster carers over the years, including them not attending training to support them as carers.

- 4.26 With hindsight, it can be seen how powerful the use of anger and aggression is and how the professional fear of how the carers would react was both a powerful grooming technique and a way of ensuring that professionals did not challenge too forcefully. The male carer was known to have a forthright and forceful personality, and there is no doubt that they regularly intimidated professionals. Either ignoring professionals or distracting them with anger and confrontation is an effective way to avoid scrutiny. The 2014 NSPCC and University of York report states that past allegations and concerns about foster carers should be carefully recorded and that any new allegations that arise should be placed in historical context. Only a few months before the allegations were made, Marie and her sibling were matched with their carers as a long-term placement. This meant that there would be less oversight and that social work visits would not be as frequent. At the time there continued to be concerns about standards of care in the placement, particularly the care and treatment of the sibling that with hindsight we can see was emotional and physical neglect.
- 4.27 The foster carers were negative about any contact between the children and their birth family, which was a pattern seen with other children placed with them previously. This was questioned and challenged by professionals but not seen as a possible indicator that the carers had anything to hide. The carers had a major bereavement shortly before the decision was made to agree them as long-term carers for Marie and her sibling. Professionals at the time felt this may account for their distant and avoidant behaviour, and their increasing tendency to be confrontational and demanding. While it is important to understand any difficulties carers are facing, there was inadequate consideration of the impact on the children and the decision to make it a long-term placement.

Learning point 5: Effectively and transparently challenging carers and ensuring that this leads to measurable improvements which are maintained and monitored.

- 4.28 Consideration of the carers' abilities and level of cooperation needed to be considered over time, including reflecting on their performance during previous placements. They had a history which included difficult relationships with many professionals. Despite this, there were numerous good examples of these professionals challenging the carers, holding them to account, and being clear about the expectations and improvements required. There is little evidence that this challenge made any difference in the longer term, however. Neither the behaviour of the carers nor the care of the children improved over time, although there were periods when things improved a bit, and professionals had fewer concerns.
- 4.29 Marie's carers had been fostering for around 20 years but tended to have longer term placements which limited the overall number of children they fostered. They were seen as experienced carers but were described as 'old-school' and 'set in their ways' by several of the professionals who worked with them. This description led to a degree of collusion with the carers' behaviour. They were challenged for not attending training, not completing the required recording or financial forms, and there were general concerns about the carers' attitude to professionals. During the consultation with professionals undertaken as part of this review, it was clear that there continued to be concerns about them. The carers were not well liked by professionals, and they tended to be seen as 'difficult'.
- 4.30 Examples of the issues that presented during the placement of Marie and her sibling include delays in the carers' providing a suitable bedroom space for the sibling, not allowing Marie to have age-appropriate independence, the male carer being verbally aggressive on a regular basis

- including in front of the children. He regularly used negative language and complained aggressively about what he perceived to be poor professional practice, often from years before. It was clear when considering what was known at the time that the care of Marie's sibling was poor much of the time, and on occasion was clearly neglectful, such as when advice from health professionals was not implemented, including ignoring advice about reducing their medication levels for ADHD, concerns from the school about their poor hygiene and the carers speaking about them negatively and showing limited insight into their special needs. When considered cumulatively, which did not happen in a consistent way at the time, it can now be seen that there was evidence of neglect. There was also evidence of emotional abuse, with numerous occasions of the sibling being blamed for their poor behaviour, despite professionals explaining to the carers the impact of their health issues and disabilities.

- 4.31 There is an understandable dilemma for professionals who know how important it is for children to have a stable placement; somewhere they feel is their home, with carers who are like parents to them. These children were desperate to have a forever home and people they could call Mum and Dad. There is also a concern about what the alternative is for children in care, with limited foster care placements. This is increasingly an issue as children get older. The Fostering Network<sup>15</sup> notes a long-term shortage of foster families in the UK. There was an assessed need for the children to remain together in placement, which would also be difficult to achieve if they were removed from the care of their carers. While it was known that the placement had its limitations and that it was not ideal, it was felt, on balance, to be the best that was likely to be available for these children, even though the carers 'repeatedly failed to meet minimum standards'<sup>16</sup>.
- 4.32 It was within this context that the carers were asked to become long-term carers for the children. A report was written that went to the fostering panel to approve the change. The report explained that there had been some concerns but that these had been addressed by the carers. It focused on the present time and recent improvements but did not reflect on the longer-term concerns and the inability previously of the carers being able to sustain a positive relationship with the local authority and long-term positive care of the children. The children had no on-going contact with their birth family, which can mean that they require additional attention from professionals. There was consideration given during the child in care reviews for an independent visitor, but Marie was clear she did not want this.
- 4.33 The carers received support from the WCC fostering service, including supervision from a fostering team social worker. They had annual reviews<sup>17</sup>. The National Minimum Standards<sup>18</sup> (NMS) for fostering were revised in 2011. Regulation 21 focussed on the provision of supervision and support for Foster Carers: It stated that the fostering service must 'support their foster carers to ensure they provide foster children with care that reasonably meets those children's needs, takes the children's wishes and feelings into account, actively promotes individual care and supports the children's safety, health, enjoyment, education and preparation for the future'<sup>19</sup>. Supporting the carers in these areas was a challenge for those providing the service.

<sup>15</sup> A charity that brings together 'everyone who is involved in the lives of **fostered** children'. They 'champion fostering and seek to create vital change so that foster care is the very best it can be.'

<sup>16</sup> Quoted from the fostering service AIR.

<sup>17</sup> When undertaking a review of the placement, the fostering social worker consults the foster carer, any children in placement during the last year, and the children's social workers and IRO. An annual review report is then written.

<sup>18</sup> The national minimum standards, together with regulations on the placement of children in foster care, such as the [Fostering Services \(England\) Regulations 2011](#), form the basis of the regulatory framework under the [Care Standards Act 2000](#) for the conduct of fostering services

<sup>19</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192705/NMS\\_Fostering\\_Services.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192705/NMS_Fostering_Services.pdf)

- 4.34 The work undertaken following the allegations and during this review have found that there is a lack of clarity regarding when concerns about a foster carer result in a Cause for Concern<sup>20</sup> and what results in a standard of care matter. For example, a carer who is verbally aggressive to professionals in front of the children could be seen as a standard of care matter and dealt with between the fostering service and child's social worker, or could result in a Cause for Concern, resulting in a multi-agency response and information sharing. If it is the latter this will be taken to the Fostering Panel at their next meeting, whereas if it is seen as a standard of care issue it will likely only be shared at the foster carer's annual review. It has been found that there needs to be more clarity within procedures and practice regarding what the response should be used. There is also a need to ensure that every separate incident is seen within the context of previous issues with the carers, to build up a picture of concerns over time, and whether, cumulatively, there is a need for action. WCC have now introduced the need for every foster carer file to have a chronology, which needs to include any concerns throughout their history as carers. This needs to be available to social workers for children placed with the carers, who should prioritise reading it.
- 4.35 In order to ensure that the plan for a child in care is meeting their needs and that the corporate parent responsibilities for a child are being fulfilled, a child in care review is held every 6 months and there is an annual health assessment. These provide an additional layer of oversight where concerns about the care provided to children in a placement can be considered. There had been several changes of IRO for Marie and her sibling, which had an impact on the oversight of the placement and care plan for the children. The IROs involved made efforts to see the children in placement outside of reviews, but this happened with their carers present. Both children were clear they wanted to remain with their carers and no concerns were identified. Marie was reluctant to provide information for her reviews or attend, but this is not unusual with children as they enter their teens. The voice of the carers is dominant in the record of the meetings, The IROs involved told the review that they also experienced the carers as dominating and forceful. They have now reflected that it would have been helpful if the fostering social worker attended reviews to provide a wider perspective of any issues with the carers and the placement.
- 4.36 The reviews focused on the need to provide support to the carers rather than raising concerns about standards of care being provided to the children. Although red flags had been raised by the IRO due to their concerns about the care of the children, there is no evidence that this led to any significant improvements. Learning was also identified in the AIR that considered the IRO service that the child in care reviews often made recommendations for the fostering social worker to work with the carers, which did not happen. Their lack of attendance would have made it difficult for them to understand the request and what was expected. There was no formal escalation about the lack of attendance or progress of the recommendations.

## **5 Conclusion and recommendations**

- 5.1 Marie had been described in agency records as often angry with low moods. She had recently been using cannabis and was receiving help and support from Mind<sup>21</sup>. Her needs were often eclipsed by her sibling's, however. Marie told the review that she was traumatised and that someone should have noticed how distressed and unhappy she was. She said professionals 'need training in how to spot the signs that something is wrong, pick up on it and do something about it. I thought people were just ignoring what was obvious.'
- 5.2 There were known concerns about the carers, including their ability to provide good care and their attitude to professionals. Professionals used the word 'intimidating' to describe them. This review has heard examples of their angry outbursts and their derogatory statements about

<sup>20</sup> This is a process that will involve the LADO and will be responded to as a potential child protection investigation.

<sup>21</sup> A mental health charity

professionals, and on occasion, the children. There was a need for professionals to have to 'manage' them to ensure that meetings and other contacts could take place. The behaviours were unacceptable from those being paid to care for the county's most vulnerable children, and there needed to be rigorous consideration of what it must be like for the children to be living with them, when professionals found them so difficult.

- 5.3 The review has found that the concerns about the carers were accepted because of a wish to ensure on-going stability for the children, the limited options of alternate placements, a wish to keep the siblings together, and a belief that it was 'better the devil you know' with experienced carers. None of those involved had considered that the children could be sexually abused in their placement. When carers (or indeed parents in other cases) are intimidating and unpredictable, this is incredibly hard for professionals. It is a good way of them being able to avoid scrutiny, professional persistence, and challenge. It is essential for professionals to support each other in these circumstances, as was evident in this case in respect of the concerns about the care of Marie's sibling. Those concerned about the carer's response to the sibling's distinct issues communicated well and provided a unified response and consistent message to the carers about what the sibling required. Again, however, it did not result in sustained changes for the child.
- 5.4 Reflective supervision is important for all professionals working with highly complex families; particularly helpful is inter-disciplinary group supervision if there are a number of professionals providing services, as there were for the sibling. Considering the learning from this review, this should include a discussion between professionals about whether a child could be sexually abused in a placement where there are concerns about neglect, emotional abuse or standards of care.
- 5.5 Significant and extensive single agency learning has been identified during the review and recommendations have been agreed to address the need for improvement actions, including single agency outcome focussed and SMART action plans which will be monitored by the Safeguarding Partnership.
- 5.6 There has been excellent cooperation with this review from the partner agencies in Warwickshire and the neighbouring authority where Marie and her sibling lived and went to school. This allowed us to establish the learning from the circumstances involving the children.
- 5.7 Having considered the learning from this review that has not been addressed in the single agency actions, the following additional recommendations are made to ensure improvements.

**Recommendation 1:**

That the partnership requests assurance from WCC about changes and improvements in the fostering services regarding:

- Use of chronologies for carers
- Clarification about when there should be a Cause for Concern or standards of care response where neglect concerns are evident in a foster placement
- The sharing of concerns with the fostering panel
- The role of the LADO
- Improved awareness of child sexual abuse and adult behaviours that may indicate risk

**Recommendation 2:**

That the Partnership advocates for the transparent, meaningful and creative offer of an 'exit interview' for children leaving care, to provide them with an opportunity to reflect on their experiences of the care system, including about their placements.

**Recommendation 3:**

The Partnership must consider how it can ensure that all professionals are aware of the learning from this review, including that the expectation that they think about and talk about the very real risk of sexual abuse for children in care.

**Recommendation 4:**

The Lead Reviewer to share the learning from the CSPR with the Warwickshire Corporate Parenting Board.