

DUDLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

Peter 17 years
John 15 years
Tom 11 years
Christopher 9 years

Confidentiality statement

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the Dudley LSCB/SCR chair.

The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved

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1. INTRODUCTION

Introduction to the Serious Case Review

- 1.1 The focus of this review is sexually harmful behaviour between adolescent males and the sexual abuse of a younger boy in a local authority foster placement. The review considers the experiences in care of four young people who at one time or another have been placed together and how sexually harmful behaviour developed between these young people.
- 1.2 The young people in question have in common some significant traumatic life experiences; they had all been removed from homes where they had been abused and neglected, they had all been adversely affected by their poor home life experiences and matching them to suitable foster placements proved difficult in every case.
- 1.3 However, it is also important to emphasise that these young people are not a homogenous group; and it may be that the most important learning from this review is that individual assessments should not lead to young people being fitted into existing provision, but their unique needs should be recognised and appropriate resources sought.

The Decision to undertake a Serious Case Review

- 1.4 Dudley LSCB agreed to undertake a Serious Case Review in this instance as the most effective way of analysing complex information on four young people and the circumstances which brought them together and enabled abuse to take place. The decision to analyse these events as a serious case review is a recognition of the seriousness of the abuse and the possible implications for practice across all agencies.¹
- 1.5 A multiagency review enables all agencies which had contact with the young people to consider their own actions in response to their needs and how they participated in the wider safeguarding network, specifically regarding exchanges of information and escalating concerns.
- 1.6 The overriding purpose of a Serious Case Review is to provide sufficient insight into the actions of all the agencies involved to enable them to understand their decision making in context and to improve the standards of competence and practice in the future.

¹ See [Working Together to Safeguard Children 2015](#) p75 for the criteria for when LSCB's should undertake reviews.

The Review Process

Terms of Reference

- 1.7 The full terms of reference for this review are contained in appendix 1.

Agencies contributing Independent Management Reviews (IMR's) to this Review

Dudley Children Social Care - individual reports on the young people
Dudley Clinical Commissioning Group - individual reports on the young people
Dudley Education Service - individual reports on the young people
Dudley Group NHS Foundation Trust - individual reports on the young people
Black Country Partnership Foundation Trust - individual reports on all young people
West Midlands Police - composite report
Dudley Fostering Service - composite report
Dudley Youth Offending Service - report concerning one young person known to the service
Dudley CAMHS - report concerning young people known to the service

- 1.8 The Foster Carers have provided a written submission, which has been shared with the panel. The Foster Carers and two of the young people in question have also met with the Overview Report author to discuss their experiences in care.
- 1.9 A practitioner seminar was held as part of the review process where twenty-five professionals from health, social care and education came together to discuss their experiences of working with some of the young people and provide context of how organisations currently work together.

Scope of the Review

- 1.10 Agencies were asked to review all relevant records relating to the subject children and young people from November 2011 (the date at which John came into LA care) or the date at which any or the other young people became Children Looked After.
- 1.11 April 2016 was determined as the end of the review period because there were no identified concerns in respect of the subject children beyond this date.

Structure of Report

- 1.12 This report is structured to provide brief relevant background information regarding the four young people and an introduction to the placement. To protect the identity of the young people and their families, identifying details have been removed and names changed. The ages given for the young people are their age at the time of the incident in February 2016.
- 1.13 Detailed concerns about practice, which may inadvertently identify individuals has been summarised, but specific evidence of these concerns has been provided to the relevant agencies.

2. BACKGROUND INFORMATION

Peter

Legal Status: Care Order.

Time in Care: 8 years 7 months

Number of placements: 4

In placement: 1 year 4 months.

Events leading to Care

- 2.1 Peter was on a child protection plan from birth due to neglect and concerns about domestic and sexual violence between his mother and father. Peter has 3 older half siblings and 3 older siblings all of whom were also the subjects of extensive abuse and neglect.
- 2.2 Peter's older siblings also had episodes in care, and records contain evidence of ongoing concerns about intra familial abuse and behaviour strongly indicating that the children had been traumatised.
- 2.3 Dudley Children's Services attempted to work with the family over a period of years, but home conditions failed to improve, the level of abuse remained high, coupled with the inability of their mother or her partner to understand the significant impact of the neglectful and abusive home conditions on the children.
- 2.4 Peter was made the subject of an interim Care Order in August 2007. Peter was 8 years old when he came into care

- 2.5 A full Care Order was not granted until February 2009 due to contested and protracted care proceedings.

Placement History

- 2.6 Peter's initial time in care was disrupted by a court directed rehabilitation plan, which seems to have caused some distress and resulted in some behavioural problems for Peter. Peter's own wish was to remain with Foster Carers but to continue to have contact with his parents.
- 2.7 An initial attempt was made to place Peter and 3 of his siblings together, this proved to be unsuccessful and Peter moved to a second family who had been approved as permanent Carers for him.
- 2.8 In 2013 Peter was found in the bedroom of a 5-year-old Looked After child in his foster home. The child disclosed to the carer that Peter had punched and pinched her and sexually assaulted her. Peter denied this and immediately requested a change of placement. Despite being in the placement for 6 years, Peter ended the placement and refused to have any further contact with these Carers.
- 2.9 The allegation was properly investigated by police and social care, Peter maintained his denial and no further action was taken by the police due to insufficient evidence. The social work response was to make a referral for specialist assessment and support after the police enquiry.
- 2.10 Peter was placed in November 2013, on an emergency basis with John and another child (who is not part of this review) and had a good relationship with them both. Clear boundaries were in place, which Peter appeared to respect. In 2014, the carer found pornography on Peter's iPod, although the details of this, and how it was dealt with are not clear.
- 2.11 In 2015 Peter went missing from the placement and was found safe and well on the south coast; he had befriended a young girl on Facebook, who was the victim of domestic violence and had gone to "save" her and return her to her family. Similar episodes of Peter going missing were recorded, which resulted in the breakdown of the placement in March 2015 and he subsequently moved to a new carer.
- 2.12 This placement of 17 months represents Peter's involvement with this Review. This is significant because John would later allege mutual inappropriate sexual behaviour between them, with the implication that Peter had "taught him" about this behaviour. Peter has always denied that anything inappropriate ever took place between them.
- 2.13 Peter's subsequent time in care remained problematic and he showed less and less inclination to work with services trying to support him. He

effectively voted with his feet with regard to foster placements; and moved to a semi-independent accommodation out of the borough. However, he was frequently absent from this and it became apparent that he had developed a new relationship and was spending an increasing amount of time with his girlfriend's family.

- 2.14 There are ongoing concerns about Peter which have been passed on to the neighbouring authority, where he now lives.
- 2.15 The IMR from Children Social Care notes that there were a significantly high number of social workers assigned to Peter during his time in Care, with 9 social workers within 9 years. This would have implications for forming any close working relationships, and building trust.

Health and Education

- 2.16 Peter attended mainstream primary and secondary school in Dudley, for most of that time the records show that he enjoyed school and was relatively successful and completed exams as a year 11 pupil.
- 2.17 However, his education post sixteen was less successful and may have been directly affected by the allegations of his involvement with inappropriate sexual behaviour. Things deteriorated to the extent that Peter was removed from college because of his disruptive behaviour and "attitude to learning".
- 2.18 It became increasingly apparent as Peter got older, that he was becoming involved in the local drug scene; on several occasions he had taken significant amounts of money and stole possessions from his Foster placements with no explanation of what the money had been spent on.
- 2.19 As a diagnosed asthmatic with a history of breathing problems, Peter had been made aware of the physical cost as well as the criminal implications of taking drugs. Furthermore, until the age of sixteen he had set his sights on joining the Army and was made aware of the problems drug use would cause him.
- 2.20 There was no specific response to the risks associated with drug use; there were several incidents where Peter had behaved in a way strongly indicative of involvement in drugs; in July 2014 he withdrew £400 from his savings and could provide no explanation for how he had spent other than "sweets". Several weeks later, he collapsed in a local bus station and was taken to hospital after taking cannabis. Peter claimed a friend had given him a cigarette, after which he started to "feel funny". There was a lack of professional curiosity about the possibility that Peter's involvement in drugs was more than experimentation.

- 2.21 It appears that Peter's drug use was never challenged although a pattern of behaviour strongly indicative of drug abuse was evident. In October 2015 Peter stole £1,360 from his Carers which he spent without explanation, and was possibly involved in a more serious theft from the Carers house a week later. In January 2016, Peter sold his TV to his girlfriends' brother in exchange for £45.00 of cannabis. His social worker refused to believe it was for his personal use, stating Peter was "against drugs". Substance misuse would have a severe impact on his behaviour, and potential offending in the future.
- 2.22 By this time Peter transferred from school to College he had effectively opted out of education; erratic attendance coincided with an increasing number of episodes where Peter was missing from his foster placement.
- 2.23 Records of Peter's post 16 education were not available to this review (post 16 education information is not recorded within the Local Authority system), so what efforts were made to retain Peter in education are not known. The Management Report provided by the Education service notes that "all PEP's² were up to date"; which implies that there was an agreed plan to support Peter's College attendance, however no details are available regarding steps to re-engage him in education.

Assessments of Risk

- 2.24 When the full Care Order was granted Peter was already placed with Carers who had been identified as suitable long-term Foster Carers for him. Peter made good progress; integrated well with the Carers and was settled at school, and he remained settled for six years. However, this changed when the other child in the placement alleged that Peter had sexually abused her. Despite having a "long and happy placement" Peter showed little attachment to his Carers once the allegation was made, and displayed no interest in maintaining any relationship with them.
- 2.25 The way Peter moved on from the placement of six years following the disclosure of abuse is also symptomatic of a pattern of behaviour in children in long term care; to move on, rather than confront challenging issues. To end all contact with Carers where he had developed a good relationship and was showing signs of achieving well at school, was in many respects taking the easy way out – although psychologically Peter was not equipped to face the consequences of what he had done.
- 2.26 Peter's social worker recognised this problem, and the potential consequences for Peter and suggested that work should be undertaken on the attachment difficulties Peter experienced. However, no work ever took

² The Personal Education Plan (PEP) is a statutory requirement for a child Looked After up to the age of 18 if they remain in education.

place on these issues. Peter's behaviour escalated from this point becoming challenging and anti-social, which led to successive placement breakdowns.

- 2.27 There were several references in case records to "investigate the cost of an assessment of the risks Peter may pose to others" being sought once the Police had concluded their investigation in December 2013 concerning the six-year-old girl, but no resource was identified.
- 2.28 Whilst it is noted that one of his allocated social workers undertook some direct work with Peter, no specific details were provided, other than Peter denied that he had assaulted the young girl in the placement in November 2013, and made no disclosures about his home life.
- 2.29 Possibly as a response to the difficulty in identifying an appropriate counselling resource, Childrens Social Care explored the possibility of school-based counselling in the summer of 2014 and a year later in September 2015 also approached the college Peter was registered with (and who permanently excluded him one month later) to provide counselling to help and support him manage his emotions. In neither case did Peter benefit from the provision of any service.

John

Legal status Care Order.

Time in Care 4 years 3 months

Number of placements: 1

In placement: 4 years 3 months

Events Leading to Care

- 2.30 John is the middle child of 3 children; he has an older half-sister who is 12 years older than him and a younger sister, 4 years his junior. Dudley Children's Services had a history of concerns about neglectful care of the children and exposure to risky adults. At various times, the children were subjects of Child Protection Plans under the category of neglect,
- 2.31 John first became a Looked After child in 2011 following a disclosure by his younger sister that he had sexually abused her, and involved another male child in the abuse (the extent of the other child's involvement and his relationship to John is unclear). As a result of the Section 47 enquiry John was accommodated under Section 20 of the Children Act 1989 and placed with Foster Carers.

- 2.32 The initial care plan was to work towards a return home to John, however, previous experience of trying to work with the family to improve home conditions had demonstrated that this would not be successful.
- 2.33 John remained accommodated under Section 20 for 10 months before a decision was made at a Looked After Child (LAC)³ review to initiate care proceedings without delay. However, there was significant drift and delay: and it was over a year before an Interim Care Order (ICO) was sought in October 2013, and eventually a full Care Order granted in February 2014.

Placement History

- 2.34 When John was initially placed with his Carers in November 2011 he was the only young person in placement, although this would change within a month and thereafter John always shared the placement with usually 3 and occasionally four young people. With one exception, the other children were all male.
- 2.35 Following the allegations of abuse in February 2016, John moved to a Local Authority Children's Home within the Borough, however, it soon became apparent that the staff in the Home could not provide the high level of supervision and monitoring which John required and he continued to display opportunistic behaviour which tested the boundaries within the placement.
- 2.36 He subsequently moved to a specialist children's home out of Dudley where he remained until sentenced.

Health and Education

- 2.37 John has a statement of special educational need and received additional help in both primary and secondary schools.
- 2.38 He has a diagnosis of ADHD and Asperger's syndrome which had been diagnosed in 2005 and 2009 respectively. Medication for ADHD was stopped in 2012 with no significant deterioration in his behaviour and his problems appeared to be predominantly based around his Asperger's syndrome. The arrangement was that he would continue to receive support from Autism Outreach Services who were supporting him in school, and available to provide advice to his Foster Carers and Social Worker.
- 2.39 Due to his diagnoses of ADHD and Asperger's syndrome CAMHS remained involved with John from 2011 onwards. Following the allegation of abuse

³ A Looked After Child (LAC) Review is a statutory meeting involving all those involved in the care of a child to plan their future care. The frequency of reviews is set out in the Care Planning, Placement and Case Review Regulations 2010.

against his sister in 2011, John was offered six sessions with a community psychiatric nurse, covering issues around sexual health, and focusing on issues such as consent, privacy and understanding boundaries. When these sessions commenced, John was still subject to bail conditions following the assault on his sister. CAMHS remained involved due to John's attendance at ADHD clinic until July 2012 when it was agreed, as John had stopped taking medication for his ADHD that there was no further role for CAMHS at that point and he was discharged. A contingency plan was in place to re-refer John to CAMHS should any mental health issues emerge in the future.

Risk Assessment

- 2.40 John had been diagnosed as having an autistic spectrum disorder in 2009. This was later revised to Asperger's syndrome in 2011. This diagnosis is significant as it should have provided a context for future assessments and interventions with John.
- 2.41 Risks related to sexualised behaviour were raised in John's placement plan from the beginning of his placement. There was a recognition that therapeutic work should be undertaken because of the sexual assault on his sister, and the abuse John had been exposed to whilst at home.
- 2.42 A decision was taken in February 2012 to refer John to a specialist service for children who display sexually harmful behaviour following an incident where he had taken his Carers phone to access internet pornography. However, there is an unaccountable delay in this work starting and it was not until December 2013 that any work eventually got underway. John received 10 sessions of therapy (4 of which were joint sessions with his sister). No records from the therapy are available, but it is unlikely that a limited number of sessions delivered 2 years after they were commissioned would have much impact on John's behaviour.
- 2.43 Further therapeutic support was offered from CAMHS, focused on sex education and understanding the rules of healthy sexual relationships. Given John's history of abuse and cognitive difficulties it is unsurprising that his apparent obsession with sex worsened in the short term following the work.
- 2.44 Further keep safe work was undertaken in June 2013, but once again this was not an adequate response to John's problems.
- 2.45 John has an extensive history of sexually inappropriate and abusive behaviour. There is almost certainly a correlation between the sexual behaviour or abuse he experienced whilst living at home and the development of his own sexualised behaviour in his adolescence.

- 2.46 An incorrect assumption was made that because of the history of John's abuse of his sister, males would not be at risk, this was an unsafe belief in itself but also factually incorrect as the abuse of his sister had also involved a male child.
- 2.47 John came into care, highly sexualised and with few inhibitions and boundaries to control his behaviour. Over the years, he was caught accessing pornography, targeting younger or vulnerable children to engage in sexual behaviour. For the most part, attempts were made to manage his behaviour through increasing monitoring and supervision and laying down very clear rules about how he behaved with other children. His Foster Carers and to some extent his school took most of the responsibility for managing his behaviour on a day-to-day basis.
- 2.48 His Carers at the time of the incident have reflected on the level of safeguarding and care they provided, their experience of caring for John for four years was that he had been totally focussed on heterosexual sexual experiences; their concern was that he would seek out vulnerable female children and they monitored and adjusted their supervision of him accordingly.
- 2.49 The Foster Carers have considered whether this level of control may have inadvertently increased the risk to vulnerable males in the household by preventing access to females.
- 2.50 The Carers were also unaware that John and Peter may have engaged in mutual sexual behaviour during the time they were placed together. Whilst Peter has denied that anything ever took place between them; it should be remembered that he was asked in the context of a police interview, and not in the context of any therapeutic work. In contrast, John has maintained that it was Peter who "taught" him about sexual behaviour and has shared this version of events with other young people engaged in the abusive behaviour.
- 2.51 As a direct result of the abuse of other boys in the placement, John eventually moved to a specialist therapeutic establishment in September 2016

Tom

Legal status Care Order.

Time in Care: 4 years

Number of placements: 5

In placement: 3 months

Events leading to Care

- 2.52 Tom's parents had split up by the time he was 3. He would later live with his mother, stepfather, and younger sister. Tom and his sister were made subject to Care Orders due to concerns about neglect and exposure to parental sexualised behaviour.
- 2.53 Tom first became known to Children's Social Care in May 2012 when he was 7 years old following a disclosure by him that he had sex with his younger sister who was aged 5. During the Section 47 enquiry other concerns about exposure to sexual abuse, neglect and parental violence emerged which resulted in Tom and his sister being accommodated under Section 20 Children Act 1989.
- 2.54 Because of these abusive experiences, Tom was highly aware of sexual acts and uninhibited about behaving sexually with his sister and towards others.
- 2.55 In June 2012, the local authority obtained an interim Care Order and a full Care Order granted in February 2013.

Placement History

- 2.56 Tom and his sister were initially placed together with a single Foster Carer in an out of Borough placement. It was apparent that Tom struggled to understand appropriate sexual boundaries and took every opportunity to touch his sister sexually.
- 2.57 Additional concerns also emerged in the placement; Tom had a mobile phone which contained indecent images of his genitals, he was 8 years old when this phone was confiscated. The carer noted that she was separating the children up to 10 times a day and Tom's sister would equally seek him out and show sexually provocative behaviour towards him.
- 2.58 The strain of constant supervision, trying to keep the children apart as much as possible and transporting the children to school in Dudley each day was clearly a great deal to ask from a single carer and she gave notice on the placement in September 2013.

- 2.59 Tom and his sister were placed with a newly approved married couple in a second out of Borough placement in October 2013. In many ways, this was a positive move; Tom and his sister both developed attachments to their Carers and started to learn appropriate ways of behaving towards adults. Ultimately, one of the Carers had personal problems which affected their ability to cope and they were eventually de-registered as Carers.
- 2.60 Tom and his sister were placed with a respite carer in March 2015 and remained there until July 2015. During this placement, Tom's sister made a further disclosure about sexual contact between herself and Tom. As a result of this a decision was made to place the children separately in future.
- 2.61 Tom moved to his fourth placement in July 2015. However, Carers gave notice on this placement in October 2015 as they were concerned about Tom's attitude to females, including another Looked After child placed with them.
- 2.62 Tom was then placed in the same placement as John and Christopher and a third child who is not part of this review in November 2015. This was planned as a "bridging" placement until a permanent home could be found. He remained in this placement until the disclosure of sexual abuse in February 2016. Following the investigation of the abuse and the Foster home Tom moved to his sixth placement in February 2016.

Health and Education

- 2.63 Tom has suffered from a number of complex but non-serious illnesses from a young age. His physical health has not always been robust and on numerous occasions he had needed to undergo further tests. There is evidence from his medical records that his health needs were often neglected by his parents and they provided unreliable care.
- 2.64 Tom also has a level of learning need; he finds concentration difficult and is easily distracted. Despite low educational attainment in his primary school years, there is no evidence that Tom was subject to an Individual Education Plan or EHCP (Education, Health and Care Plan), although one has subsequently been devised at his current school.
- 2.65 Tom's intellectual and cognitive abilities make integration into social groups difficult for him. This has been compounded by changes of placement, which has prevented him from forming friendships with his local peer group. His level of immaturity means he gravitates towards playing with younger children - which becomes more problematic as he gets older.

Risk Assessments

- 2.66 The need for therapeutic work for Tom and his sister was identified in September 2012; a psychological report, commissioned for the care proceedings recommended a specific therapeutic input. The LAC reviews indicate that the decision to seek support from CAMHS would be pursued once Tom and his sister were settled in a permanent placement. This however became a very protracted process, leading to significant delay in seeking therapeutic support and highlighted the shortfall in appropriate resources for children like Tom who engage in sexually harmful behaviour.
- 2.67 Tom's social worker made concerted efforts in 2013 – 2014 to refer him to relevant agencies in the region, but all attempts were unsuccessful as agencies did not consider that Tom met their referral criteria.
- 2.68 Tom was eventually referred to a psychotherapist in private practice and funding secured for twenty sessions. The therapy commenced in August 2014. The psychotherapist also began life story work with Tom as this had been delayed, despite being a re-occurring recommendation in his Looked After reviews.
- 2.69 The therapeutic work had a positive effect on Tom and relationships with his Carers. The eventual breakdown of this placement exacerbated Tom's attachment difficulties and he was overwhelmed by feelings of grief and loss at the ending of this placement, believing that somehow it was his fault.
- 2.70 Fortunately, the psychotherapist continued to work with Tom bridging the change of placement. In July 2015, Tom disclosed to the therapist that he had been sexually abused by his stepfather and began to describe the traumatic impact this had on him. However, the funding to continue this therapy was not approved despite being strongly supported by his social worker and Independent Reviewing Officer (IRO). In her final report, the psychotherapist also expressed a view that she believed there were more disclosures to come from Tom.
- 2.71 The well-founded fear was that in the absence of therapeutic support, Tom would move from placement to placement; a course of events which would damage his ability to make attachments and reinforce a negative view of himself.

Christopher

Legal Status Care Order.

Time in Care: 8 years

Number of placements: 9

In placement: 7 months.

Events leading to Care.

- 2.72 Christopher comes from a complex family where intergenerational sexual abuse was prevalent. As a young child, his development was severely affected by long-term confinement to his pushchair or baby bouncer. This has caused long-term behavioural and psychological problems.
- 2.73 The inability of his parents to protect Christopher and his 3 siblings from exposure to risky adults was one of the most important reasons he was taken into care.
- 2.74 All four children were removed in February 2008 and placed with Foster Carers.

Placement History

- 2.75 Christopher and his siblings were removed in 2008 and placed with Foster Carers. Christopher was initially placed alone, but was moved to be with his younger sister. However, within that placement his sister displayed sexualised behaviour on 2 occasions necessitating separate placements to be identified for her and Christopher.
- 2.76 Following his separation from his sister. Christopher began to show patterns of behaviour which were previously unknown, he screamed at night and could be aggressive and disruptive. The Carers were unable to cope with his behaviour and ended the placement. Christopher's behaviour would prove to be a challenge in subsequent Foster placements.
- 2.77 Christopher developed some bizarre behaviours, was known to be cruel to animals and had attachment issues, particularly with female Carers. He could also be impulsive and seemed to have no sense of danger.
- 2.78 In early 2009 Christopher was placed in a specialist Foster Care Centre where he remained for 3 years, which was significantly longer than first planned. The original intention was to find an adoptive placement and work with Christopher and the prospective adopters to provide a permanent home. The Centre was unsuccessful in identifying a suitable

adoptive placement and the plan changed to securing long-term Foster placements for him.

- 2.79 Christopher moved to a prospective long term foster placement in September 2012. Unfortunately, this broke down after 9 months, he then spent 2 years in a Childrens Home before moving into the same foster placement with John and another Looked After child in July 2015.

Health and Education

- 2.80 Chronic neglect had left Christopher with several significant emotional and behavioural problems and difficulties in forming attachments. These were comprehensively assessed during his time in the specialist residential placement.
- 2.81 Christopher's need for a specialist placement was the result of a behavioural assessment in 2009 which recognised Christopher needed 12 - 18 months of therapeutic care, although he would remain at this unit for three years.
- 2.82 A later clinical assessment in 2014 concluded that Christopher may be at risk of developing mental health issues in the future.
- 2.83 Christopher has been diagnosed with ADHD. He has a statement of educational needs and attends a special school.

Assessment of Risk

- 2.84 The abusive care Christopher has experienced from his birth family and the numerous rejections he experienced had contributed to the difficulty of finding a suitable permanent placement for him. Christopher was assessed in 2009 as needing specialist therapeutic help to enable him to live with a permanent substitute family.
- 2.85 The failure of this led to a succession of placements which broke down, primarily because of the stress of managing his behaviour. The effect of placement breakdown was described by the therapist at the Specialist Unit as follows:
- “This would be a very confusing experience for any child but for one who has not developed a sense of himself in the world, this would be especially confusing and would impact on his ability to learn the skills that he needs to function within relationships. However, the more that Christopher displays this behaviour the more he is rejected by Carers and the less likely he will develop a secure relationship with anyone”.*

- 2.86 Following the breakdown of his fourth placement, Christopher was placed inappropriately in a children's home for two years, where he was usually the youngest resident.
- 2.87 This placement was eventually terminated by his IRO, escalating his concerns that Christopher was drifting in care. This led to his placement with John and Peter, where he would eventually be sexually abused.

4th Young Person in placement

- 2.88 Although the fourth young person in placement does not feature in this review, because it has been established that he was not involved in the abuse and had no knowledge of the abusive behaviour, it is important to remember that he was a significant presence in the placement who affected the dynamics between the young people and was an additional responsibility for the Carers.
- 2.89 He was also an adolescent male and had been in the placement seven months when the abuse became known. He was a strong and challenging personality and managing his likely response to the discovery of the abuse was an additional demand on the Carers and Childrens Services.

The Foster Placement

- 2.90 The Foster Carers became Dudley MBC approved Foster Carers after transferring from an Independent Fostering Agency in September 2012. They are experienced and competent Foster Carers who have adapted their home and their lifestyle to care for adolescent males.
- 2.91 The decision to move from a fostering agency to the local authority was taken to preserve John's placement with them. At the time, Dudley was seeking to reduce their dependence on external providers and bring placements back "in house". By becoming local authority Foster Carers, they were able to ensure that John could remain in their care.
- 2.92 They were approved for 2 children (3 if siblings) 0-18 (with a preference for 10-18) male only. The approval for males only was based on the risk assessment that John only posed a risk to females. The risks that John posed were not re-assessed and all subsequent reviews of managing the risks posed by John were therefore flawed.

Summary of Background Information

- 2.93 The context of the abusive incidents was a busy foster home, in an authority short of suitable resources both in terms of accommodation and necessary therapeutic support. The four young people in placement at the time of the abuse did indeed share some characteristics in terms of exposure to inappropriate sexual behaviour, neglectful parenting and, with the exception of John, several changes of placement. However, there were important differences which affected how their needs could be met. John and Tom had come into care after years of abuse and neglect, Christopher in contrast, came into care at a relatively young age and had not been the subject of abuse. Their chronological and developmental age span was broad and they made different demands on the Carers. Success with John had led to an overconfidence in the ability of the Foster Carers to prevent abusive behaviour occurring within the home, but it is ultimately the responsibility of Children Social Care to manage the placement as a resource.
- 2.94 The decisions to place these four young people in the same placement were taken in isolation, recognising the individual need of the young person, but not considering how they would interact with each other. Approvals for the placement were obtained retrospectively with little or no evidence of management oversight or challenge.

3. INCIDENT LEADING TO THIS REVIEW

- 3.1 In February 2016, Christopher disclosed witnessing sexually inappropriate behaviour between John and Tom, he also disclosed that he had been sexually abused by both John and Tom, the incidents have occurred in the Foster home and only when another Looked After child (placed in the home, but not part of this review) was out of the house.
- 3.2 The Carers immediately passed on the allegation to Social Care Emergency Duty Team (EDT). The Carers took immediate steps to safeguard Christopher and separate him from the other three boys. The matter was referred to the Police by EDT and a strategy discussion followed the next day.
- 3.3 Each of the four boys in the placement was the subject of a Section 47 joint enquiry⁴. Christopher disclosed that the abuse had taken place over several months and was clear that neither the Foster Carers or the other

⁴ Where information leading to concern that the child is suffering or likely to suffer Significant Harm, Section 47 of the Children Act 1989 describes the necessary action to be taken by Police and Social Care.

foster child was aware of the abuse. The joint investigations also established that Tom had also been the victim of sexual abuse perpetrated by John and should be considered as a victim in his own right. It was established that the sexual abuse by John of Christopher and Tom had been perpetrated in each other's presence, and they were able to corroborate each other's testimony.

- 3.4 John admitted the offending, and was able to describe the grooming process; an escalation of sexual touching, leading to intercourse all perpetrated within the Foster home.
- 3.5 The fact that the investigation has established that the abuse had taken place within the Foster home raised some concerns about the actual level of supervision the Carers provided. The local authority convened a "Position of Trust"⁵ meeting at the end of March 2016 to properly consider how information about the potential risks have been shared, and how the Carers had supervised the children in placement.
- 3.6 The Position of Trust meeting concluded that there was nothing to suggest that the Foster Carers had neglected their duty of care to any of the children and the level of supervision and care in the Foster home was of high quality. However, it did raise concerns about some of the practice of Children Services in relation to placement decisions and failure to consider the impact on children already in the placement.
- 3.7 However, as Foster Carers, they are also part of a team working on behalf of the Council, and it is a reasonable expectation that they would receive some support and guidance. Unfortunately, in this case, following the disclosure of the abuse they had no contact from anyone from the Department with responsibility for the young people for twelve days, even though they were still caring for two children. Clearly the train of thought which eventually led to the position of trust meeting was that in some way they were implicated in the abuse or their negligence had allowed it to happen.

4. ANALYSIS

Variations in Fostering Approval.

- 4.1 The legislation covering Foster placements is clear⁶; the usual fostering limit for any Foster Home will be three children, except where the children are

⁵ Position of Trust Meetings are held where there are concerns raised about a professional or volunteer who works directly with children to ensure that these allegations are managed in an appropriate manner.

⁶ [Exemptions and Extensions/Variations to Foster Carer Approval](#)

siblings. It should be remembered that the approval for these particular Carers was for two young people, or three if part of the sibling group. In reality, they had routinely had three young people in placement since January 2013.

- 4.2 Applications for an exemption to these limits must be agreed by the local authority prior to placement being made. The process for obtaining an exemption should provide checks and balances to ensure that the needs of other children in the placement had been considered and there is agreement that the Foster carer is the most appropriate option to meet the child's needs.
- 4.3 An agreement to an exemption should be signed by the designated manager and the decision reviewed by the Fostering Panel. The Fostering Panel will then be responsible for the ongoing monitoring of the exemption.
- 4.4 A variation in the Carers terms of approval was necessary to place a fourth child (Tom) with the Carers as this took them over the agreed fostering limit.
- 4.5 It is unclear whether the variation to the Foster Carers approval was considered a temporary or permanent change, in any case, the fact that it lasted longer than six days meant that good practice would have been to seek the approval of the Fostering Panel.
- 4.6 The decision to place four vulnerable children together was not the result of a considered understanding of the dynamics of the placement. John may be considered as the resident child; in the sense that this was the only placement he had known, and he had been with the Carers the longest. The other children were added incrementally in full knowledge that, from November 2014 onwards, their placement breached the placement approval limits and in some cases managers sanctioned these approvals retrospectively.
- 4.7 These decisions were taken within the framework of how the placement would meet the needs of that particular child, rather than how the child would affect the other children already in the placement. There was an over-reliance on the Carers ability to ensure safe caring practice with little professional input from Children Social Care.
- 4.8 It is also apparent that several workers; both social workers and IRO's, had knowledge of a number of the children, having previously been their allocated worker. It would therefore have been possible to have an informed discussion about the impact the young people would have on each other.
- 4.9 The review has identified several occasions when there was a significant lack of management oversight of the placement; between August and

October 2013, a female child moved into the placement, a decision which placed her at significant risk based on the existing assessment of John as having an obsessive interest in girls and exhibiting risky behaviour. No variation of the carer's approval can be found on their case file.

- 4.10 Christopher moved into the placement in July 2015 age 9 and was placed alongside John and the other adolescent male not part of this review. Because Christopher was younger than the preferred age group the variation was formally approved, but this approval made no mention of the other children in placement and their problems.
- 4.11 The placement plan makes no reference to Christopher's family history or difficulties in previous placements. In November 2015, Tom moved into the placement, alongside John, Christopher, and the other young person not part of this review. This was planned as a temporary placement (until January 2016) because no other placements were available. The Carers have stated they felt reticent about Tom joining the household, but did not want to reject him and trigger another move close to Christmas, and based on their management of the other boys in placement felt they could cope.
- 4.12 However, there was no management agreement on the updated exemption, and the appropriateness of the placement seems to have been left to the allocated social workers, supervising social worker and Foster Carers. An exemption for (Tom) to be in the placement was signed in retrospect by a manager in mid-December.
- 4.13 The exemption form did not consider any of the risks posed by the children being placed under exemption or the children already in placement; in particular no reference to the risks posed by John.
- 4.14 The exemption should have considered the views of the social workers for all of the children, the Foster Carers, the supervising social worker and made reference to any concerns about the potential risk from placing four vulnerable children together.

Responding to Sexually Harmful Behaviour

- 4.15 John was known to have a long-standing problem with sexualised behaviour; a level of sexual knowledge and an interest disproportionate to his chronological age. The assumption was made that because of the abuse he had suffered and witnessed he had developed distorted thinking about sexual relationships. These early life experiences combined with his diagnosis of Asperger's syndrome make it difficult for John to control his behaviour and learn the rules about sexual boundaries.

- 4.16 In addition to the abuse he witnessed and experienced whilst at home there are a series of concerning episodes which arose whilst John was in care; these included several attempts to access pornography over the Internet, sometimes in the company of older males. John showed a very noticeable interest in younger and more vulnerable girls, which eventually would prevent him from attending swimming lessons and youth clubs. In November 2015, one of the Foster Carers raised concerns about a recent incident where John was discovered with Christopher sitting astride him. The Carer was so concerned she requested further therapeutic support for John.
- 4.17 The Foster Carers were vigilant in noticing these concerns and reported them appropriately; their concern is evident in the way they described John's "predatory behaviour" and at one point even described him as "a sex offender waiting to happen". However, despite these concerns being shared with other professionals at LAC reviews they were never recorded on the Looked After Health Assessments.⁷ The interpretation of John's behaviour was that he had an obsessive interest in young and vulnerable females and he was not thought to have any sexual interest in males.
- 4.18 Even at this stage of the Section 47 enquiry in February 2016, when Christopher had disclosed being abused by John. The Police and Social Care had no record of these previous concerns.
- 4.19 Given John's history any of these incidents could have been the subject of a Child Protection Strategy Meeting, which would have served the purpose of collating these concerns, and possibly considered that the issue of vulnerability of the person, rather than their gender was possibly more important for John in identifying potential victims.
- 4.20 At the present time, Dudley, are one of nine Local Safeguarding Children Boards in the West Midlands who have develop and work to the West Midlands Regional Safeguarding Procedures. These does not contain detailed procedures on working with Sexually Active Children and Young People (including under-age sexual activity).⁸ There is limited information on "Peer on peer child abuse" which does not provide any specific guidance for responding to young people who sexually abuse others, but takes a more general educative approach, concentrating on learning about sexual boundaries and consent issues.

⁷ While the school nurse expressed concerns, they would not necessarily have been known to the designated nurse for Looked After Children. This is another example of the importance of formal inter and intra agency communication.

⁸ [Sexually active children and young people \(including under-age sexual activity\)](#)

The importance of early intervention

- 4.21 In the context of this review early intervention, refers to the availability of therapeutic support for Children Looked After. Given the nature of the abuse the young people suffered in their families of origin, early intervention strategies to improve parenting were unlikely to have improved home conditions.
- 4.22 Therefore, it is imperative once young people such as these come into the care system their needs are properly assessed and therapeutic support should ideally be available to help them adjust to the experience of being looked after away from their family.
- 4.23 The usual resource considered to address these needs is CAMHS, however, on several occasions these young people did not meet the threshold criteria, even for a referral into CAMHS; either because they did not have a diagnosed mental illness or they were not in stable placements. Paradoxically, the lack of therapeutic support makes the prospect of a stable placement even less likely.
- 4.24 Tom's case provides a good example of what can be achieved through the provision of appropriate therapy at the right time, it is evident from the case records that the psychotherapy he received whilst in out of Borough placements not only supported the placement itself, but also helped Tom process some of his own abusive experiences, including disclosure of historical abuse. The cost of such therapy pales into insignificance compared with the cost of a specialist residential resource.
- 4.25 A further aspect of early intervention for young people in care, which can be overlooked is the provision of life story work. It was not the usual practice in Dudley for this to be undertaken by the allocated social worker, although it could be argued that they are best placed to undertake this work and it could potentially serve the function of building a relationship between the worker and the young person. Life story work has developed a mystique of its own and is viewed as too specialised too time consuming to be undertaken by the allocated social worker. The consequence of this is often that no work is attempted, although its absence is routinely raise at LAC reviews.
- 4.26 It must be recognised that this is important work, not an optional extra in helping the young person to adjust to being looked after outside of their family home.

Social Work Practice

- 4.27 The social work practice considered in this review is highly variable and involves the practice of some workers no longer working in Dudley. The best practice is characterised by workers showing resourcefulness and tenacity in attempting to find resources outside of the local authority to meet the needs of these young people. These workers would usually be the same ones who maintain contact with the Foster Carers and spent time getting to know their young people and creating the opportunity to meet with them individually outside of the usual requirements of a LAC review or other formal meeting.
- 4.28 In contrast, the poor practice evident in this review is characterised by workers allowing cases to drift, poor communication with other agencies and failure to pass on concerns. At its worst, these practitioners have little or no effective relationship with children allocated to them, and in some cases moved on without saying goodbye or introducing a new worker.
- 4.29 It may be that these workers underestimate their importance to young people in care, but even if they feel they do not have a good relationship they are still statutorily important and the failure to respect the feelings of the young person can be damaging to a fragile ego.
- 4.30 A particular failing has been the lack of assessment of risk of children in placement. There is little evidence of any social work practice aimed at understanding the level of risk, rather, there seems to be a reliance on the Foster Carers observations of looking after the children on a day-to-day basis. In situations such as this where young people are motivated to abuse and had developed strategies to avoid detection in the Foster home, this is clearly unsafe practice.
- 4.31 The pressures on Dudley Children Social Care during 2014 – 2016 should also be recognised as a factor in the department's ability to meet the demands placed on its staff and resources. The Ofsted Inspection Report published in April 2016⁹ provides a detailed picture of the difficulties faced by the Department in meeting its obligations. Staff working in the Borough at the time have described the additional pressures of inconsistent and temporary staff (including managers and supervisors) and caseloads as high as 50 cases. In a climate where workers are responding to crises it is almost inevitable that professional standards cannot be maintained.

⁹ [Dudley Metropolitan Borough Council Inspection of services for children in need of help and Review of the effectiveness of the Local Safeguarding Children Board](#)

Assessment of Carers Abilities

- 4.32 The Carers were recognised as experienced and competent with particular skills in fostering adolescent males. They had a track record of coping with young people who presented challenging behaviour and as such were a scarce resource in Dudley.
- 4.33 Given that the fostering limit was frequently exceeded, there was no real sense of what a safe limit for the placement might have been. It seems to have been left to the Carers rather than Children Services to determine how many children could be cared for safely. Clearly, in the absence of any proper placement planning meeting (which should consider the individual needs of the children in the placement) these decisions were based on the carer's willingness to accept the child.
- 4.34 The Carers were recognised as being able to offer a safe, placement with clear "safe caring" rules in place. The Foster Carers are not naive individuals and have the personal and life experience that are a prerequisite for caring for adolescent males. However, the focus seems to have been on the physical and structural aspects of safe caring with house rules about respecting individual personal space managing bedtimes etc. In practice, one of the young people involved has confirmed that they found it relatively easy to engage in sexually harmful behaviour in the home because they knew the routine of the Carers and could hear where they were in the house.
- 4.35 The way the abuse took place under the noses of the Carers whilst they thought they were being vigilant is not in itself unusual. It is a common finding that abusive acts can take place very quickly and discreetly. One of the reasons such abuse goes undetected is that it occurs in a setting which parents and Carers would consider too risky or too public.
- 4.36 There are several examples of the young people "sharing" an IRO or a social worker, yet the decision to place them in the Foster home seems limited to how the Foster Carers would manage that particular child without considering the impact on the "Foster family".

Post Abuse Support

- 4.37 All of these young people have been chronically neglected, the significant differences between them were how long this neglect was known before the local authority intervened and the extent to which they had been abused prior to coming into care, in no case did the child receive meaningful therapeutic intervention in a timely way: in all cases where therapy was offered there was a significant delay in accessing the appropriate resource and it would seem it was often left to the tenacity

and creativity of individual workers or the Foster Carers to identify appropriate resources,

- 4.38 It is important to note that these were children who could be worked with - when they were offered the appropriate therapeutic support.
- 4.39 Recent national research¹⁰ recognises that all professionals have a part to play in supporting the wider mental health needs of Children Looked After and should be trained to recognise and respond to these needs. The report also suggests that professionals should assume that neglected children coming into care are likely to have mental health needs:
- “The corporate parent should enhance a child’s quality of life as well as simply keeping them safe. In order to raise ambition for looked after children, elected members and senior leaders must act like ‘pushy parents’, working hard to ensure the best for looked after children through asking the question, ‘is this good enough for my child?’” (p24)*

Failure to escalate concerns

- 4.40 Dudley LSCB has a Resolution and Escalation Protocol in place to resolve professional disagreements and address situations where a worker within one agency believes that another is not adequately safeguarding a child¹¹. This protocol enables agencies to formally raise concerns with each other regarding safeguarding issues. In addition, Dudley Children’s Services own procedures also address dispute resolution in a similar way, which are the appropriate procedures to address concerns internally, including placement decisions, social work practice and fostering.
- 4.41 The resolution of differences of opinion is essentially a stepped process with the intention of resolving differences face-to-face between professionals wherever possible, and using the management hierarchy when these attempts have failed.
- 4.42 A common experience of the four young people subject to this review was drift and delay in enacting decisions taken at LAC reviews. In these situations, the IRO has a statutory responsibility to formally escalate concerns with Children Social Care, and there are examples of good practice when the IRO did this, in relation to delays in seeking therapy and the unsuitability of a residential placement, but on no occasion, were safeguarding concerns about the overcrowded placement escalated by the IRO or any of the workers for the young people.

¹⁰ [Improving mental health support for our children and young people](#) SCIE November 2017

¹¹ [Resolution and Escalation Protocol](#)

4.43 Staff from other services also expressed their disquiet about lack of progress in LAC reviews, but again there are few examples of these concerns being formally escalated. The failure to use the multi-agency arrangements is a typical finding of Serious Case Reviews¹². The reasons for the inconsistent use of these procedures range from workers feeling they have insufficient time to use the process (clearly at times during the period under review workers were under extreme pressure because of high caseloads), lack of awareness of the procedures (again during the period under review cases were held by locum and agency staff) through to a lack of confidence in a manager's ability to resolve problems.

5. LEARNING

- 5.1 The abuse in this case did not take place because the placement was over-crowded - although the number of young people in the placement at the time was more than the agreed limit.
- 5.2 Abuse occurred because John had a long-standing problem with sexualised behaviour, there had been several near misses in the past where abuse had been prevented by the vigilance of Carers and this need was not addressed despite being raised on several occasions. John was clearly motivated to abuse and has a history of testing boundaries and seeking opportunity. Lack of assessment led to a theory about his offending; that he was attracted to girls and therefore boys would be safe, this was based on partial information and not a thorough assessment.
- 5.3 It is clear from the family histories that the four children, discussed in this review could not be cared for safely by their birth families and the decision to remove them and eventually seek Care Orders was the correct and safe decision to make at the time.
- 5.4 However, it is also apparent that apart from Tom, none of the children received the necessary therapeutic support that would enable them to adjust to foster care and start to address some of the long-term effects of the neglect and abuse they have experienced whilst at home (while John had received some therapeutic input this was delayed for two years and did not adequately address his problems with sexual behaviour). There is a significant gap in provision for therapeutic support and to address some of the problems caused by damaged attachment. This is not a separate need; it is part of the reason the children were removed from the families in the first place and a recognised problem at the point they entered the care system. But to only address their physical needs and not seek to address their psychological and emotional damage only partially protects their well-being.

¹² [Unresolved disagreement about the need for children's social care involvement](#)

- 5.5 Whilst these children required specialist therapeutic support they also had more basic needs which were not addressed by the local authority. The children passed through the hands of numerous Foster Carers, social workers and other professionals and few seemed to have the time, or skill to get to know the young people and take an interest in their day-to-day well-being.
- 5.6 Social workers play an essential role in fulfilling the caring responsibility of the corporate parent; they are the human face of this responsibility and need to have the time and support to exercise this in a way which makes sense to young people.
- 5.7 It is important that workloads will allow social workers to exercise their responsibility properly. As stated above, part of the organisational context of this review was a department under extreme pressure with an unstable workforce with high caseloads.
- 5.8 At times like this, it is often the case that a culture arises where tasks which are important but not essential are given less priority. However, it may be that although the working environment improves, the working practices do not, and it is necessary to address the custom and practice which has arisen as a response to managing at a time of crisis and allow workers to use the additional time for the benefit of young people.
- 5.9 With regard to fostering as a resource, Dudley did not have sufficient Carers in order to provide suitable placements for these young people. Caring for a child who has been traumatised by abusive experiences is a difficult and skilled task, Dudley is no different from most other local authorities in struggling to recruit suitable Carers.
- 5.10 It is important therefore to look at how Children Services managed this particular Foster placement, which was a valuable resource, and the degree of management oversight into the decision to place these children together. In this case the fostering approval did not in effect mean very much; it was breached and compromised on several occasions and managers were happy to sanction this through exemption certificates or variation notices.
- 5.11 Proactive management is particularly important in these situations to mediate between Carers trying to do their best and social workers who may advocate for their particular child, in the knowledge that this is a good placement albeit crowded, and knowing that the alternative may be less desirable, both in terms of the skills of the carer and geographical location.
- 5.12 The discovery of sexual abuse within the home is devastating for any parent or carer and perhaps even more so when Carers are assuming the

responsibility for keeping someone else's child safe. The impact on the Carers should not be underestimated, it has caused a good deal of soul-searching and questioning of their decisions. They have also continuously reflected on whether there were signs which they have overlooked. The same painful processes which most parents and Carers go through.

- 5.13 It is also important to try and understand the barriers to using formal procedures for escalating concerns; Conflict Resolution has been a standard organisational tool in place for several years and it is not sufficient to claim that failure to use it is due to lack of familiarity. The professionals most likely to have recourse to it were IRO's who were experienced practitioners and managers, who have the responsibility for escalating concerns as part of their statutory duty¹³. But with a few exceptions relating to delays in the provision of therapy, delays in social workers submitting care plans and (after two years) raising concern about Christopher's placement in a Children Home, concerns were not escalated by the allocated IRO.
- 5.14 Allocated Social Workers could also have raised concerns through supervision and more formally using the Resolution Policy. The reasons for this need to be explored further; if professionals had mentally "adjusted" to a lack of resources and expect poor standards on behalf of the young people they are responsible for, possibly because of the state of Childrens Services at the time, they were unlikely to raise concerns. It is a leadership and training priority to challenge poor standards and support social workers (and all those with a statutory responsibility) to seek the best for their children.

¹³ [IRO Handbook](#) Dispute Resolution and Complaints p45

6. RECOMMENDATIONS.

Procedures.

1. Dudley LSCB should require Children Services ensure that the procedure on variations and exemptions to the usual fostering limit is adhered to. An independent audit of current practice should be undertaken to ensure compliance with the statutory guidance.
2. Dudley LSCB should review the protocol for Position of Trust meetings to consider the need to provide support for individuals subject to this process.
3. Dudley LSCB should produce child protection guidance procedures specifically for young people who display sexually harmful behaviour. This guidance should address the investigation, assessment of risk and need for intervention.
4. Dudley LSCB should require Children Services to urgently review the current practice for the safe care plans made as part of the placement process. Safe care agreements should not be generic and need to consider the risks posed by individuals with consideration of how this will affect the placement.
5. Dudley LSCB should, through training and audit, ensure compliance with placement procedures; specifically:
 - placement planning meetings should take place prior to placement.
 - when the placement is planned, placement planning meetings should be attended by social workers for all children placed where the children have additional needs,
 - the needs of all the children in the placement must be considered and,
 - there is recorded management oversight of this process.
6. Dudley LSCB should require Children Services and the Education Department to ensure that the post school education of Children Looked After is monitored and every effort is made to keep young people engaged in further and higher education.

Practice

7. Dudley LSCB should convene a multiagency group (Children's Social Care, Police, YOS, education and CAMHS) to review the current provision for young people who display sexually harmful behaviour.

8. Dudley Children's Services should review its current fostering strategy to focus on recruiting Carers able and willing to take one child only to meet the demand for such placements.
9. Dudley Children Services should review the current Independent visiting service to ensure it complies with its statutory responsibility and is available to all children where it is in the child's best interests.
10. Dudley LSCB should ensure that the learning from this Review and the Social Care IMR regarding Peter are shared with CAFCASS. This recommendation is made in the light of the Guardian ad Litem's opposition to the application for a Care Order in 2007 resulting in a period of instability for Peter which lasted for over 2 years.

Training

11. Training for all professionals who work with Children Looked After on the use of the Resolution and Escalation Protocol.

Appendix 1

Terms of Reference for Each Agency

Analysis of involvement

Consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but why something either did or did not happen.

Consider specifically the following and critically review the practice in your agency:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of services for children? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication (both within the authority and between authorities), information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hour's services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was there sufficient management accountability for decision-making?
- Was the work in this case consistent with the policy and procedures for safeguarding in each organisation and the LSCB, promoted the welfare of children and was consistent with wider professional standards?
- In considering this aspect of the case, the reviewer needs to decide whether the context in which the case was conducted impacted on decisions made. The reviewer should be able to evidence any assertions made possibly through policies, operational practice at that time, professional/management judgement or research.

What we learn from this case

This section should set out the lessons learnt from this case, including:

- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children?
- Is there good practice? Highlight this, as well as ways in which practice can be improved
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations;
- Are there any implications for how resources are used?
- Are there implications for current policy and practice?

Recommendations for action

Recommendations should fully address the practice issues raised in the review rather than just relate to processes – ask ‘what will change if the recommendation is implemented?’ and ‘what will improve the outcomes for the young people

From the findings and subsequent recommendations in this report, the DSCB has devised a specific plan for the Local Authority's Corporate Parenting Board to provide assurance. These relate to recommendations 1, 4, 5, 7, 9 and 11.

The author of this report has agreed with this approach.

Ensure the Recommendations are clearly taken from the body of the report, and have charged the DSCB to ensure that actions should include: -

- What changes (if any) could be made in inter-agency working in the light of this case?
- What action within the agency should be taken in the light of its findings?
- What areas of good practice are there? Could these be expanded?
- What action should be taken by whom and by when?
- What outcomes for children should these actions bring about?
- How will the agency know whether they have been achieved?

Ask yourself what action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved? Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

Consider what evidence can be used to show that the Actions have been completed.

The recommendations should be Specific, Measurable, Achievable, Realistic and Timely (SMART).

Recommendations should be linked to the issues raised under ‘What do we learn from this case?’, and be clearly set out.

Agencies should use the attached Action Plan Template to monitor progress and record progress.