Chapter 1
Introduction

This study, commissioned by CoramBAAF, is the first to focus primarily on children who had been abused or neglected while living with foster carers, adopters or special guardians. This is a group of very vulnerable children for whom the state bears responsibility, as the corporate parent, for making arrangements for them to live safely and securely. What follows is an exploration of what happened to those who suffered serious harm or death and then became the subject of a local safeguarding review.

The study examines case reviews from across a dozen years (2007 to 2019) and identifies issues and themes that emerge. At the heart of the study is discussion about the pitfalls that were encountered and how professional culture, systems and practice in relation to these vulnerable children can be strengthened and improved. All this is set against the background of a very challenging environment for families and professionals in which to try and deliver care, support and a service that is always in the best interests of each child.

The findings are aimed particularly at practitioners and those managing and providing services for fostering, adoption and special guardianship, and members of fostering and adoption panels. The study has important messages for many disciplines, including child care social workers and supervising social workers, independent reviewing officers (IROs), and associated professionals in health, education, probation, police, immigration and court services. It is also relevant for a wider audience of those with responsibility for policy and practice in relation to safeguarding children.

The authors have written a companion guide to reflective practice that is intended to be read in conjunction with this study. This short guide discusses the key issues identified from the research and sets out a series of questions for practitioners based on the findings.

CONTEXT OF CHILDREN LIVING WITH FOSTER CARERS, ADOPTERS AND SPECIAL GUARDIANS

The last 30 years have seen an unprecedented growth in the numbers of children entering care in England and Wales. As a result, in 2017,

local authorities in England and Wales 'had larger numbers of children in care than ever before' (Thomas, 2018, p.15). The inevitable pressures on existing local authority resources to meet the care needs of these children have been compounded in the last decade by a range of interrelated socio-economic factors. These factors include increasing levels of child poverty and family homelessness, at the same time as the implementation of Government fiscal policies of austerity and cuts in public services. The Select Committee examining the funding of local authorities' children's services in 2019 concluded:

> *Financial restraint combined with seemingly ever increasing demands on the sector is leading to what has been described as "a perfect storm".*
>
> (House of Commons Housing, Communities and Local Government Committee, 2019, p.3)

As at 31 March 2019, the number of children looked after in England was 78,150 (Department for Education (DfE), 2019a), three-quarters of whom were being cared for by foster families (Lawson and Cann, 2019). The steady rise in numbers has put enormous pressure on the supply and availability of foster carers, and on fostering services. Most placements are arranged through and overseen by local authorities themselves (Ofsted, 2020). During 2019, the number of local authority foster households in England remained static. In contrast, there has been a two per cent increase in the number of approved foster households provided by the independent sector (Ofsted, 2020). However, the latest data suggest that there continue to be 'fewer places available for children who needed foster care than in previous years' (Ofsted, 2020).

The situation has been exacerbated as a result of the coronavirus pandemic. From 1 March to 23 April 2020, the number of referrals to Barnardo's fostering services increased by 44 per cent while the number of people looking to become foster parents for the charity fell by 47 per cent compared with the same period in 2019. They report that:

> *... this has created a "state of emergency" as children who may have experienced abuse and neglect wait for places with loving foster families. Without more potential foster carers coming forward, hundreds of children referred to Barnardo's will not be placed with a family.*
>
> (Barnardo's, 2020)

A key Government policy has been to ensure that children in care experience family life that gives them security and permanence as they grow up. There has been considerable pressure on local authorities in England to increase each year the numbers of adoptions of children in the care system. This has had a measure of success. However, the number of looked after children in England who leave local authority care as a result of adoption has fallen by one-third in the past four years. A total of 3,570 looked after children were adopted in the year ending 31

March 2019. This contrasts with an increase in the numbers of children who left care through a special guardianship order, an outcome for 3,830 looked after children during the same period (DfE, 2019a). The DfE is urging a renewed focus on adoption as a permanence option (DfE, 2020a).

Not all placements proceed as planned. In 2018–2019, 5,815 children and young people in foster care (7%) were reported as having experienced unplanned endings of their placements, of whom 31 per cent were moved within 24 hours (Ofsted, 2020). There are no national statistics available for adoption disruption, but estimates are that between four and ten per cent of adoptions fail after the adoption order has been made (Selwyn *et al*, 2015). A disruption rate for special guardianship placements over a five-year period has been calculated at five per cent (Simmonds *et al*, 2019, p.12).

Placement disruption is an under-researched, complex area, and any statistics need careful examination and explanation (Selwyn *et al*, 2015). There is currently little evidence of an association between abuse and neglect of children living with foster carers, adopters or special guardians and placement disruption (Biehal *et al*, 2014).

IMPACT OF FUNDING CUTS ON CHILDREN'S SERVICES

As a result of the Government's austerity policies, local authority spending in recent years has not kept pace with demands for children's services (Thomas, 2018, p.32). A shortfall in children's social care funding was calculated by the Association of Directors of Children's Services (ADCS) and the Local Government Association (LGA) to be £2 billion (Thomas, 2018, p.63). The consequences of this were recognised by the Select Committee in 2019:

> *It is clear that current funding levels are unsustainable. Local authorities are responding to increasing demand and decreasing spending power by prioritising child protection work and reducing spending on non-statutory children's services. Despite these efforts, most local authorities are still overspending their budgets on children's social care.*
>
> (House of Commons Housing, Communities and Local Government Committee, 2019, p.3)

Alongside local authorities' limited and diminishing resources, there is evidence of increased use of private providers (Ofsted, 2020). Ray Jones (2019) has expressed concern that, in the private sector, the interests of shareholders or the owners of provider agencies can become as important as the quality of services provided. He suggests that this unrecognised growth in private for-profit provision within children's

social care, including foster care services, raises worrying questions, not least the escalating costs to the purchasing local authorities.

PRESSURES ON THE SOCIAL WORK WORKFORCE

To work effectively to promote the well-being and safety of looked after children depends on there being sufficient, competent and caring social workers who are able to access and be supported by expert line management. This generally-held principle is currently being undermined by a number of factors, including difficulties in workforce recruitment and retention, pressures of practitioners' caseloads, and the culture of media and political "blame and shame" in which practitioners may find themselves working.

The Department for Education's (2020b) official statistics show that, for the period ending September 2019, vacancies stood at 16.4 per cent of the total children and families' social work workforce in England. The difficulties in recruiting permanent staff have resulted in an increasing dependence on private social work employment agencies. This has had an impact on the stability and quality of the children's workforce, and on local authorities' budgets, as employing agency staff inevitably results in higher costs than permanent staff:

> *As of September last year, 26 authorities got more than 30 per cent of their children's social work staff from agencies.*
>
> (Perraudin, 2019)

The size of social workers' caseloads is another issue. There appears to be a "postcode lottery" in relation to both caseloads and unfilled vacancies (DfE, 2020b). The average caseload carried by children and family social workers in 2019 was 17.4 cases, but varied greatly between local authorities, from 12.1 cases in one authority to 32.7 in another. Vacancy rates also differed, being highest in London, with 24 per cent unfilled vacancies (DfE, 2020b). A theme from submissions to the Care Crisis Review was concern about the increasing complexity of cases and the challenge this created in terms of planning and service provision (Thomas, 2018). Many social workers report that their professional ethic of helping is undermined 'because of a lack of early help and support services available, the rising nature of thresholds and the lack of time to spend with families' (Frost, 2019).

A further strand is the wider environment, which has seen 'a growth in the culture of blame and an increased need for scapegoats' (Dingwall and Hillier, 2015, p.x). Social workers are all too aware that they may face media and political criticism and have an ever-increasing fear of getting things wrong. The Care Crisis Review reported:

> *A recurring theme in contributions to [care crisis] Review meetings and in written submissions about policy and practice was about an increasingly risk-averse and blame culture that pervades public work. The Review was told that fear of being vilified publicly and judged to have failed to prevent a child's injury or death haunts many professionals.*
>
> (Care Crisis Review, 2018, p.24, para 3.13)

The issue of blame and shame is an important contributory factor in local authorities' ability to retain their workforce. A diminished workforce, together with the turnover of staff and high caseloads, will inevitably impact on the quality of work carried out by children and family social workers.

A feature of the 52 case reviews studied was that there was no evidence of seeking to blame or shame individual staff, but the emphasis was on learning and improvement of professional culture, systems and practice.

SOURCES OF EVIDENCE ABOUT MALTREATMENT OF CHILDREN IN CARE

To ensure that the findings of this Good Practice Guide build on previous work on children who have been harmed or killed while living with alternative carers, other sources of information have been sought and examined. This was done in order to cross-check the findings from this guide and to gain a sense of the scale and extent of abuse by foster carers, adopters and special guardians. The search has revealed limited evidence, other than from serious case reviews, on the extent of abuse in foster care, adoption or special guardianship (Biehal *et al*, 2014).

Earlier public inquiries and reviews have been influential in shaping public and professional understanding of what happens when children, living in the care of others, are maltreated. They have also had an important role in informing subsequent legislative change.

The Home Office inquiry (conducted by Sir Walter Monckton) in 1945 into the death of Dennis O'Neill was the first to examine in detail the circumstances of what happened to a child and his brother in foster care (Cmd. 6636, 1945). A far-ranging Government Care of Children Committee had already been set up and reported in 1946. It was charged with enquiring into:

> *...existing methods of providing for children who from loss of parents or from any cause whatever are deprived of a normal home life with their own parents or relatives; and to consider what further measures should*

> *be taken to ensure that these children are brought up under conditions best calculated to compensate them for the lack of parental care.*
>
> (Cmd. 6922, 1946)

The Committee's recommendations for the closer supervision of foster homes and their careful selection were clearly influenced by the death of Dennis O'Neill, and subsequently incorporated into the significant post-war legislation, the Children Act 1948 (Parker, 1999).

When Peter Reder and colleagues, some 40 years later, came to study 35 fatal child abuse inquiry reports from 1973 to 1989, they found many of the children in their study had been 'temporarily placed outside the household with extended family, previous partners or in the care of social services' at the time they died. Four of the children concerned had been in foster care or adoptive families (Reder *et al*, 1993, p.35). Their study broke new ground, and the insights into the "family-professional systems" and "professional networks" continue to be valuable and relevant, and are mirrored by findings in this study (see Chapter 6).

A scrutiny of biennial and triennial reviews of serious case reviews in England also informed the context of this study. These highlighted, for example, the vulnerability of older children and those with additional needs, such as disabled children, posing challenges for effective service provision (Rose and Barnes, 2008; Sidebotham *et al*, 2016). Other reviews drew attention to overwhelming caseloads, lack of professional confidence and insufficient qualified staff, uncertainty about information sharing, and the lack of rigour in assessment, analysis and plans (Brandon *et al*, 2009; Sidebotham *et al*, 2016). Most recently, the work of Marian Brandon and colleagues (2020) highlighted, among other important messages, the fragmentation of services, the need for clear multi-agency plans, and the importance of thorough assessments, suitable monitoring and support for children living with special guardians.

Finally, court judgements provided valuable insights through their detailed analyses of complex issues. Two, in particular, raised issues about the consequences of institutional failures on the lives of children. One related to two unconnected young people, where Mr Justice Keehan highlighted the impact on children's welfare of the inappropriate use of accommodation under s.20 of the Children Act 1989. The foster carers of both children were highly commended, but the local authority was severely criticised for failing to act in the best interests of the children. The judge commented that these were the 'most egregious abuses of section 20 accommodation it has yet been my misfortune to encounter as a judge' (*Family Law Week*, 2018).

The other court judgement, made by Mr Justice Jackson, highlighted the consequences of failing to revoke freeing orders on two brothers once the plan for adoption had been abandoned. As a result, 'in the ten

years since the making of the order, the boys had no natural person with parental responsibility for them' (*Family Law Week*, 2012). The local authority action in relation to these two boys was seen to have been unlawful, as it breached their 'right to respect for private and family life'.

> *Over a 14 year period, A and S were moved from one foster family to another, becoming increasingly unsettled and disturbed. A had moved backwards and forwards between placements 77 times in his 16 years of life, and S had moved 96 times in his 14 years of life. The boys suffered physical and sexual abuse while in foster care.*
>
> (Chesterfield, 2012)

AIMS OF THIS STUDY

This study focuses on serious case reviews undertaken between 2007 and 2019 and which related to children living with foster carers, adopters or special guardians. A broad interpretation of what constituted a "serious case review" was taken. It encompassed a wide range of safeguarding practice reviews commissioned by Local Safeguarding Children Boards and included an Independent Inquiry following criminal proceedings.

The aim was to identify key issues, themes and challenges for practitioners and their agencies, working singly and collectively, and to draw out the learning for policy and practice.

The criteria for inclusion in the sample were:

- reviews published from January 2007 to July 2019;
- cases of serious harm and child death while living with foster carers, adopters or special guardians;
- wherever possible, cases to be drawn from the four nations: England, Wales, Northern Ireland and Scotland.

Accessing reviews

A variety of sources was used to identify reviews, including the NSPCC website and its archives, a search of relevant literature, and contact with key Government officials and academics in Wales, Scotland and Northern Ireland. At the time of the study, all nations had either reformed or were in the process of reviewing their systems for serious case reviews (or the equivalent).

The Working Together guidance 2018 for England introduced a new framework of child safeguarding practice reviews that changed the criteria for triggering a review from the previous guidance in 2015 (HM

Government, 2018). It established new working arrangements, replacing local safeguarding children boards with safeguarding partners and introduced the Child Safeguarding Practice Review Panel to oversee the operation of local and national safeguarding reviews (HM Government, 2018; NSPCC, 2019). The arrangements for publication were confirmed:

> *Safeguarding partners must publish local reviews and the panel must publish national reviews, unless they consider it inappropriate to publish.*
>
> (NSPCC, 2019)

It soon became clear that it would not be possible to include findings from Northern Ireland in this study. The Safeguarding Board for Northern Ireland is responsible for deciding whether an executive summary of a Case Management Review should be published. Periodic reviews that focus on specific issues, and include children living with foster carers, have been published and have been explored (see for example, Devaney *et al*, 2012; 2013). Only two executive summaries had been published in Northern Ireland since 2012, neither of which met the criteria for this study.

Including the findings from Significant Case Reviews (SCR) from Scotland also proved difficult because, once a review is completed, it is the responsibility of the child protection committee to decide whether to publish the full report or just an executive summary. Since 2012, the Care Inspectorate in Scotland has become the 'central collation point and undertakes qualitative evaluation on all significant case reviews' (Care Inspectorate, 2019, p.1). Overviews of SCRs have been periodically commissioned in Scotland and relevant ones have been scrutinised (Vincent, 2010; Vincent and Petch, 2012), as have the Care Inspectorate's more recent overviews of SCRs (Care Inspectorate, 2013; 2016; 2019).

At the time of publication, Serious Case Reviews (England), Child Practice Reviews (Wales) and Significant Case Reviews (Scotland) were being sent to the NSPCC by the respective Safeguarding Board or Partnership and made available through the NSPCC website for three years. They were thereafter stored in the NSPCC archives. However, discussions with the Head of Knowledge and the Senior Information Specialist responsible for the NSPCC repository painted a less certain picture. Although Local Safeguarding Children Board websites are routinely scanned for any missing reviews, the NSPCC could not be certain that all reviews had been identified and included in its repository. Staff had also noted an increase in requests to the NSPCC for publication of reviews to be anonymous.

METHODS OF ANALYSING THE DATA

A search was made of the NSPCC national case review repository and the websites of individual Local Safeguarding Children Boards to locate as many published reports of serious case reviews, and their equivalents, as possible for inclusion in this study.

A total of 52 completed reviews were obtained by the end of July 2019. These included:

- English Serious Case Reviews = 45 (4 of which concerned unnamed local authorities);
- Welsh Serious Case Reviews and latterly, since 2013, Child Practice Reviews = 6;
- Scottish Significant Case Reviews = 1.

We have used "serious case reviews" as a generic term for the 52 reviews in the study and often use the term "review" to avoid repetitiveness.

A mixed-methods approach was used to analyse the data. This included a quantitative and qualitative analysis of the full sample of 52 serious case reviews or their equivalent. Such an approach provides much information from which to draw out the implications for policy and practice.

An initial scrutiny of the reviews showed that no consistent approach had been taken to conducting the review. The methods varied, and included those described as:

- multi-agency deep dive review (refers to the extensive use of multi-agency chronological data);
- hybrid systems methodology (focuses on both continuous time variables and discrete events);
- blended methodology (a conscious mix of research methods to exploit their strengths and weaknesses);
- Appreciative Inquiry (a management approach that focuses on strengths rather than weaknesses to identify what is working well and why, in order to improve practice).

There were also significant differences in the form of the reviews. In some cases, a full review was available. These varied in the detail they gave and ranged from 27 to more than 80 pages. In other cases, only a brief summary report was obtainable. A few reviews had been redacted, in some cases making them unreadable and incomprehensible. Others had been published anonymously, and had redacted the identity of the local authority and the safeguarding board.

The reviews also varied in the extent of the information they provided about the child and family. For example, in a number of them, information on the child's age, gender, disability and ethnicity was not recorded. The inclusion of a genogram was not routine, making it difficult to make sense of often very complex family relationships. These omissions, although impacting on the veracity of the research, are understandable in the context of preserving the privacy of the child or birth family.

The timeframe was a publication date of the review between January 2007 and July 2019. This meant that in some cases the recruitment of carers and the placement of children had occurred under legislation, policy and practice of the 1970s, 1980s and 1990s. Although major changes in legislation have taken place since the 1970s (see, for example, Lord and Cullen, 2016, in relation to adoption legislation and guidance since 1989), similar themes emerged from the reviews, regardless of whether they were historic or more recent cases.

To compare the sample in the current study with that included in the triennial review of serious case reviews 2014–2017 (Brandon *et al*, 2020), the same details were extracted. This information was coded onto a Microsoft Excel spreadsheet for analysis, and included:

- demographic characteristics (region, residence, age, gender, ethnicity, disability prior to incident);
- category of death or serious harm;
- source of harm/perpetrator;
- social care involvement.

In addition, because the study focused specifically on cases involving children living with foster carers, adopters or special guardians, understanding the process and quality of the assessment and approval of carers was an important issue.

All 52 reviews were also subjected to a qualitative analysis where the focus was on the individual child or children. The analysis involved inductive, open coding. This meant that the reviews were read and re-read in order to identify themes, patterns and relationships common to the reviews. These were compared with data from relevant literature. The findings are illustrated with quotations (presented in italics) drawn from the serious case reviews and reproduced from the orginal. The results from the qualitative analysis provided insights into and an understanding of how and why these tragedies occurred.