Leicester Safeguarding Children Partnership Board

WORKING TOGETHER TO KEEP CHILDREN SAFE

Local Child Safeguarding Practice Review (LCSPR) 'Child C and D'

Lead Reviewer: Karen Perry

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Foreword

This review concerns two children, known here as children C & D, who were abused by one of their foster carers.

No-one wants to think that foster carers could be capable of abusing those in their care, but practitioners who work with vulnerable children must have processes in place to help them minimise the risk of abuse and be alert to when the unthinkable happens.
The children were moved from the placement on the same day one of them reported the abuse. C has bravely talked to an independent reviewer to share her experience and help to identify what could have been done differently to better protect her and her sister.

Children must be supported and encouraged to feel they can report abuse to practitioners involved in their care and be given the right environment to do so.

Since this review, which was carried out in 2021, a range of actions have been implemented including: work undertaken with a national organisation who have expertise in supporting professionals to identify and respond to child sexual abuse, and facilitated workshops with the fostering service, reminding them that foster carers and special guardians can also be abusers, and how to make use of the processes in place to identify this.

The fostering service has taken action to ensure that essential activities designed to minimise the risk of abuse are in place and monitored, and that learning from this review has been incorporated into local practice.

It is the job of the LSCP to ensure these actions are built into day to day working and that all agencies continue to work to the best of their ability to protect children and young people in Leicester.

Foreword written by Amanda Boodhoo, Independent Chair, Leicester Safeguarding Children Partnership Board

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INTRODUCTION

1.1. This Child Safeguarding Practice Review is in respect of Children C and D. Child C made an allegation of sexual assault (digital penetration) against her male foster carer to school staff and the police. Child D told school staff she had been touched over clothing by the same carer in a way that made her feel uncomfortable. The carer denied the allegations. The Local Area Designated Officer (LADO) processes[1] considered the allegations to be credible, but prosecution was not pursued because of the lack of corroborative evidence. Child C was a teenager at the time of the allegations and Child D was of junior school age. All learning points are listed in section 4, at the end of each theme. What follows is a summary of the most significant learning from this review.

Key learning points

1.2. Children are more likely to provide views honestly if they have a strong relationship with the practitioner and, especially for younger children, if techniques of direct work are used which avoid a direct question-and-answer approach. Relationship building could be better done more naturally as part of another activity, for example collecting children and young people from school. Children raising concerns need to feel safe, this may include a need to be seen alone and outside the placement and practitioners need to find ways to make this an appealing prospect to children and an expectation for both carers and children. Practitioners knowing that children are in contact with several practitioners can give false reassurance that, if there were something to disclose, that children have people to talk to Children may be more inclined to disclose concerns if they know how they are likely to be handled and what the likely outcome will be (e.g. placement ending).

1.3. It is hard for practitioners to “think the unthinkable” that foster carers might sexually abuse children and local policies do not acknowledge this either. Beliefs that placements are “settled” and perceptions that carers are capable can provide false reassurance that children are safe and well cared for. It is also not easy for agencies to identify the threshold between what might be understandable behaviour for a parent/carer at a stressful or frustrating moment, but which is not the kind of “professional” behaviour that should be expected from a foster carer.

1.4. Organisational processes to minimise the possibility of inappropriate or abusive behaviour by foster carers are important. They include ensuring carers do relevant training, including safeguarding and safer care training; updating safer care policies according to the needs of the children placed; unannounced visits; seeking the views of other practitioners and family members for annual reviews, and addressing any concerns promptly. Fostering panels provide an important layer of additional scrutiny, any presentation to panel for whatever reason (all assessments and reassessments, the first annual review) should clearly identify any standards of care concerns, previous and current, as well as any allegations and describe how they have been dealt with

Publication and methodology

1.5. Leicester Safeguarding Children Partnership Board (LSCPB) will ensure that learning is widely disseminated locally and this report be published. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning. The Child Safeguarding Practice Review takes into account multi-agency involvement

[1]A Local Area Designated Officer (LADO) is someone employed by the local authority to manage and oversight allegations made against people that work with children.

for the children; from May 2018 (when the children were placed with the foster carers) until March 2021 (when Child C made the allegations of sexual assault), and for the foster carers from July 2016 (when the carers first applied to be foster carers) until March 2021 (when the children were removed from their care).

1.6. Leicester Safeguarding Children Partnership Board (LSCPB) agreed to undertake this review using a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time. The chronologies in the Rapid Review[2] reports were enhanced by additional material that reflected the longer timeline identified in the Terms of Reference. Practitioners attended two virtual meetings led by the author and had opportunities to comment on draft reports. Family members were also offered the opportunity to speak to the lead reviewer. Child C and Step Paternal Grandmother agreed to do so; their comments are included in section 5.

2. DETAILS OF THE FAMILY AND CASE CONTEXT

2.1. Family members and other significant adults will be referred to by their family relationship to Child C and Child D or role e.g. Mother, Father, Sibling, Mr. and Ms. X (the foster carers) etc. At the time of the allegation that prompted this review the children were living with the foster carers. Both children are White British as are the carers. During the period covered by the review Child C has been described as a popular girl who appeared mature for her age, and as having a strong moral compass and engaging well at school when feeling motivated. Child D was described as a happy and resilient child who has good friends at school where she engaged well. Both children have a strong relationship with their older sibling with whom they have regular contact. Mother was not directly involved in the children's lives during the time they lived with the foster carers. Records describe the children as enjoying reading, swimming, and shopping. Child C enjoys cooking especially baking.

3. THE CHILD AND CARERS' STORIES

3.1. Some information prior to the scoping period is relevant. Before being in the care of the local authority, the children had been subject to child protection plans[3] (September 2010 to January 2012 and August 2017 to March 2018). This was mostly due to concerns about Mother's poor mental health, misuse of alcohol, and the poor emotional and physical home environment. Father committed domestic violence against Mother, the children were exposed to this.

3.2. In July 2017 the children were taken into care due to Mother having assaulted Child C. As a result of social work enquiries requested by the court when Father made a private law application to care for the children himself, the court issued first Supervision and then Care Orders.[4] In May 2018, prior

[2] Rapid reviews should gather information from all agencies involved with a child to establish whether there is any immediate action needed to ensure their safety and the potential for practice learning including making a recommendation to the chair of the safeguarding partnership whether the criteria are met to commission a Child Safeguarding Practice review

[3] A Child Protection Plan is made when a child is judged to be at risk of significant harm. The Plan statest the specific risks to the Child Cnd the actions that will be needed to keep the child safe.

[4] Where a child is made subject to a Care Order, the Local Authority is given Parental Responsibility and will share it with current Parental Responsibility holders, for example, the child's parents. However, the Local Authority can exercise their Parental Responsibility above that of other if necessary to safeguard the welfare of a child.

to the final court hearing, the children moved to live with the foster carers where the subsequent alleged abuse prompted this review.

3.3. Between July and November 2016, the fostering service had begun an assessment of Mr and Ms X regarding their suitability to be foster carers. The assessment did not progress to a full assessment because of concerns that the male carer would not be able to work well as part of a team or be willing to complete all fostering tasks and take advice from practitioners if it did not match his own views. In November 2016, because of a positive reference from a 3rd party in a position of influence, and further letters and meetings internally and with them they were allowed to redo the preparation training and for the assessment to be restarted. The couple were subsequently approved as short-term foster carers[5] in February 2018, the male carer was the primary carer (the female care was in employment). Prior to the children being placed with them, Mr and Ms X had had one short respite placement. By October 2019 the placement was considered to be meeting the needs of Children C and D. A Permanency Planning meeting concluded that the children should remain there for the rest of their childhood, subject to a reassessment of the carers as long-term carers by the fostering social worker. This led to a decision by the Agency Decision Maker (ADM) taking into account the recommendation of the fostering panel, to change the carers' approval criteria to long-term match in April 2020.

3.4. During the period under review there were some concerns about Child C's emotional wellbeing. In August 2018 she disclosed suicidal thoughts to the GP, in October 2018 she cut herself on two occasions, again in February 2019, and in May 2019 after Father died by suicide. Both children were offered support from the Bereavement Service. They declined this[6]; instead Child C accepted support from the school nurse. In February 2020 Child C cut herself while fully clothed in the bath[7]. Because of suicidal thoughts she was referred to the Child and Adolescent Mental Health service (CAMHs) and had 14 sessions of treatment.

3.5. In March and June 2019, there were two incidents of a sexual nature, [redacted] and Child C making an allegation of sexual touching by a peer respectively, both while in school. The multiagency response to the second incident in particular was responsive and of good quality. The professionals' and carer's actions, led to Child C feeling able to progress with a police complaint against the perpetrator. She also received counselling.

3.6. There were no concerns about the carers reported until December 2018. However, between then and September 2020 there were four concerns reported to or observed by social workers about the behaviour of the male carer. These involved an "aggressive tone" with school staff, explicit comments about Child C's menstrual cycle in public, and overfamiliarity/lack of boundaries with the children. These were each addressed individually with the carers by the fostering service.

3.7. In mid-April 2020 the Fostering Independent Reviewing Officer (FIRO) noted the concerns whilst checking the records in preparation for the carer's 2nd annual fostering review. This resulted in a

[5] The meaning of the term short term in this context is until a permanency plan for the child is made either to return home or stay with foster carer. Sometimes this means a move to other carers already approved as short-term carers, often as in this case consideration will be given to changing the carers' approval status to long term to enable a long term match to be considered

[6] Child C confirmed that the offer of bereavement service was declined because it was too late – eight months after their father had died.

[7] Child C confirmed to this review that this was more than self-harm and was a suicide attempt, as she had a genuine intention of ending her life and did not at that time only mean to harm herself.

"mapping meeting" towards the end of April 2020 where social care practitioners shared their unease about the behaviours of the male carer. The carers' reassessment report presented to panel a few days earlier did not include any details of these behaviours and the practitioners' unease. This meant that neither the panel nor the Agency Decision Maker had opportunity to take them into account.

3.8. In March 2021 Child C told a teacher that both she and Child D were being sexually abused by the male carer and that the female carer knew about this. Both children were moved to a new placement the same day. Child D made a disclosure to a teacher the following day.

3.9. The allegations against the foster carers were investigated by the police and the LADO convened a series of multiagency meetings to consider the safety of any children who had contact with the carers. There was no evidence to substantiate the allegation about the female carer, but practitioners considered that the children's allegations about the male carer were plausible. The fostering service put the carer's registration on hold, preventing any further placements. The carers resigned, but, to safeguard other children, the fostering service's recommendation for deregistration was accepted by the fostering panel and Agency Decision Maker in September 2021.

4. THEMATIC ANALYSIS

4.1. The learning from this review was identified from information and opinions provided in the agency reports and at the practitioner event and from family members. The themes are:

- **Children's voice and disclosing abuse**
- **Recognising and addressing children's vulnerability to sexual abuse**
- **Assessment of foster carers, support, monitoring and matching**
- **Management of incidents, concerns, complaints and allegations about foster carers**
- **Support for the children**

Theme: Children's voice, and disclosing abuse

4.2. Practitioners are required to seek the views of children in care before making decisions that affect them and they need to be available physically and emotionally for children to be able to raise or explore sensitive topics. Children are more likely to provide views honestly if they feel safe and have a strong relationship with the practitioner and, especially for younger children, if techniques of direct work are used which avoid a direct question-and-answer approach. Children also often find it easier to discuss sensitive topics if they can avoid eye contact, e.g. doing activities alongside the adult, in the car, doing the washing up going for a walk. Relationships of trust require practitioners to have strong interpersonal skills and are assisted by regular contact which involves an element of fun and demonstration of genuine interest in the child, i.e. not just "business", and an appearance at least of plenty of time to go at the child's pace.[8] Conversely, no matter how skilled the practitioner, building trusting relationships is made harder without continuity of worker, and frequent contact in person.

[8] Lewing B et al (2018) Building trusted relationships for vulnerable children and young people in public services Early Intervention Foundation

4.3. Practitioners involved in this review gave examples of how they built relationships, for example spending time with children which was not part of a statutory visit, attending events that celebrated the child's success or interests in some way, e.g. dance shows, attending parents' evenings, going to school breakfast clubs. However, some children, especially older children, do not like it when social workers come to their school. Primary school staff described a range of strategies for encouraging confiding conversations, "worry monster" post its, three houses tool (of worries, good things and dreams), and a cosy room suitable for a private chat, when children have put a peg up on a line to request a visit there.

4.4. Supervising social workers (SSWs) should develop relationships with the children placed with their carers and speak with them when they visit. Challenge for SSWs include that there is no requirement for them to see children alone; the primary role of the SSW and reason to visit placements is to support carers and conduct supervision. Perhaps unsurprisingly therefore children tend to see them as the carer's social worker. Children's Independent Reviewing Officers (IROs) should also visit children which was achieved in this case. However, it is the children's social worker who has the lead role in engaging with the children and eliciting their views about their care and care plans. At her first statutory review[9] in September 2018, which was well attended by an appropriate range of practitioners, Child C confirmed that she felt she was seeing her social worker sufficiently often. However, at the second review in September 2018 she requested to see the social worker more often at a time when she had recently been expressing suicidal thoughts. The social worker visited her in October and November 2018.

4.5. Maintaining a relationship was not helped by social work visiting arrangements that changed from 6 to 12 weekly in April 2019 once the children had been placed for 12 months. Strictly speaking that was not in line with local guidance[10] which indicates that this change should not be made until it has been agreed that the placement will last until the child is 18 years, i.e. that the placement is a permanent one. This was not agreed at a permanency planning meeting until October 2019 and the final approval for the match not completed until after the Agency Decision Maker had approved the carer's suitability as long-term carers in April 2020. This last step is an important one because although preliminary matching of current needs and suitability and consideration of all parties' views can be done at a matching meeting, assessment questions about the ability to meet the needs of the children for several more years, and for the rest of their childhood, considering motivation and commitment to them as young adults and contingency planning, are not appropriate in that setting.

4.6. Once placements are deemed permanent, local guidance indicates that social workers should visit more often than every 12 weeks if the circumstances warrant it, when the child reasonably requests it or when there has been a complaint or an allegation. The social worker did visit when then there was a complaint or allegation or incident. However, there is limited evidence of any discussion in supervision about what the ongoing visiting frequency should be in response to some of the vulnerabilities experienced by Child C, for example the self-harming and the sexual assault. The social worker told this review that another challenge was that her relationship with Child C

[9] Children in care have statutory reviews chaired by an Independent Reviewing Officer 4 weeks after coming into care then after a further 3 months and then 6 monthly unless a significant event or proposed change in the care plan means a review should be held earlier

[10] https://www.proceduresonline.com/llr/childcare/leicester_city/p_sw_visits.html

deteriorated after visiting her because of the Sibling's reported concerns. It is not known why that was and there is no evidence of any reflection at the time about why that might be.

4.7. The Coram BAAF study of SCRs[11] involving approved substitute carers includes examples of how foster carers may also subtly affect practitioners access to the children by pressurising them to resist being seen outside the house, and/or restricting their candour by quizzing them on what they tell practitioners or rebuking them, or otherwise making them feel uncomfortable (as Child C told this review she felt) if any issues the children raise are subsequently taken up with the carers by the practitioners. Social workers told this review that they always offered the opportunity for the children to be seen outside the home, but Child C was adamant she did not want this, and then Child D followed her older sibling's lead. Therefore, the children were never seen outside their placement by the social worker, and the action from the mapping meeting to do so was never completed. This is important because children can feel constrained in what they say if they are seen in the placement, even if the carer is not actually present in the same room. The male carer was the primary carer; he was the carer mostly at home when social worker visited.

4.8. The children who were the subjects of another local SCR involving sexual abuse by a foster carer told that review that there were too many changes of social workers with visits too infrequent to build up a trusting relationship. It was frequently recorded in their case notes that the children refused to be seen alone, however during the review the children explained that the carers made them tell them what they had said and that everything they said got repeated back to the carers. One of them said "*maybe we should have just been taken"* which suggests perhaps they might have agreed to be seen alone if the social worker had been more directive. Child C told this review that relationship building would be better done more naturally as part of another activity, for example collecting children and young people from school, and that she had been conscious of the carers being nearby when seen in the home. For all foster carers it should be a clear expectation that children will be seen alone and outside the placement. If children then refuse there needs to be some reflection about why they are refusing. In both the previous review and this one there is no evidence of discussion as to why this might be, or how the question could be put so that the children would be likely to agree to see the social worker outside the placement, or circumstances contrived to achieve that result.

4.9. Challenges for the Looked After Children (LAC) nurse service in seeking children's views include changes of staff and the fact that the children were only seen once per year, as per statutory requirements, which poses challenges in building relationships from the child's point of view despite LAC nurses' skill and experience in building rapport in these circumstances. In addition, prioritisation during Covid meant only virtual contact and that LAC nurses did not attend statutory reviews or send any information to them unless there were known to be safeguarding issues or significant health issues. These things combined impeded the ability to establish a trusting relationship. In addition, Child C declined the offer to be spoken to alone at her two annual health assessments. In the other local SCR previously referred to those children did not access the confidential slot with LAC nurse either, learning from that review included that the social worker should be informed and the reasons for declining should be enquired about and recorded. Since then, these issues are included in the reports sent to social workers and IROs and records are subject to monthly audit.

[11] Cleaver H and Rose W (2020) Safeguarding Children living with foster carers, adopters and special guardians; Learning from Case Reviews 2007-19 Coram Baaf

4.10. The CAMHS involvement was during restrictions due to Covid. All but one of the assessment and weekly sessions between April and September 2020 were conducted using phone. As for all practitioners using virtual means an additional challenge is being able to view body language or see who else is there. Carers were present for the initial assessment and two reviews of progress; midway and at the end. Records for the 4th and 5th sessions show Child C had asked for information not to be shared with the foster carers and so the CAMHs worker discussed and agreed with her what was necessary to share so that they could support her.

4.11. Records show that the children explicitly told several practitioners, SW, IRO LAC nurse, school nurse that they were happy with the carers and the placement was seen as a settled and stable one. In January 2020 for example the supervision record for the children's social worker indicates that the children were seen as settled in a placement that meets their needs with visits conducted 12 weekly; '*the social worker rarely hears from carers as they are very capable and just get on with things",* This was also the view of the family placement service. Examples given include reporting concerns facilitating the counselling and other appointments, and not appearing overwhelmed by any caring tasks over the three years.

4.12. Children being happy and settled was also a feature in the local SCR previously referred to. This was said then to have resulted in limited social work visits to the children. This belief about "settled" placements seems to have provided false assurance to both sets of practitioners. It is also a relevant context when the carers were being assessed and approved as suitable to be long term foster carers Fostering staff told this review that the standards of care policy developed since this review which applies to all carers where two or more concerns have been identified would cause reflection about cases that are perceived as "settled" and that supervision of supervising social workers is more robust in terms of interrogating the evidence when a child is deemed as "settled."

4.13. A recent study commissioned by the Office of the Children's Commissioner for England[12] involved young people as co-researchers to explore young people's perspectives on disclosing abuse and neglect; what helps and what hinders.[13] The research identified that young people weigh up the advantages and disadvantages of disclosure, and that their previous experience of how practitioners and agencies have responded to disclosures, as well as their experiences within their families and in the community, are relevant.

4.14. The study categorised the process of telling into four themes: *hidden; signs and symptoms; prompted telling; and purposeful telling*. The abuse (or self-harm) being *hidden* could be either a lack of recognition of a problem or alternatively actively hiding or denying a situation. *Signs and symptoms* might involve risky or "difficult" behaviour or internalising behaviours, such as self-harm. *Prompted telling* could happen in the context of a relationship with a trusted person and/or an initial sensitive enquiry or a response to a hint from a young person about their situation; telling can be a process over time rather than an event. *Purposeful telling* involves the young person deliberately approaching someone to tell, as Child C did. This is not a linear process. Recognition might come because of conversations with practitioners who were alert to the potential underlying causes of behaviour, or

[12] Cossar J et al (2013) 'It takes a lot to build trust' Recognition and Telling: Developing earlier routes to help for children and young people Office of the Children's Commissioner for England
[13] The study involved a literature review, analysis of content of a peer support website, detailed interview with 30 vulnerable young people aged 11-20 years and focus groups of a broader same of young people not known to be vulnerable accessing services and parents and practitioners

discussions with the young person after hints, or indeed not until after help has been received from specialist services.

4.15. Young people in the study described different strategies about choosing who to tell. Sometimes this was a particular agency, for example the police to stop the abuse, or a practitioner who they knew would pass on the information to others. Young people in the study also recognised that sometimes it was necessary for practitioners to pass on information to others without the young person's consent, which if done transparently and discussed openly with the young person, could result in enhanced rather than reduced trust. Facing up to telling was clearly very difficult emotionally; some young people rehearsed strategies by writing down key points. Face to face telling even a trusted person could be difficult; one alternative strategy mentioned in both the interviews and the website analysis was to hand over a letter to a trusted professional for them to read when the young person was not present.

4.16. The study identified five main barriers to disclosure identified by the young people. In order of importance these were: "an emotional barrier, e.g. shame, embarrassment, not being able to face telling, finding it hard to find/say the words; worry about the family knowing, loyalty to family and the impact on family members; thinking their situation was not problematic enough to disclose to others; threats from the abuser; and fear of not being believed if they were to tell."[14] The literature survey also identified an additional barrier to disclosure as being a fear of a loss of control over decisions. Child C told this review that a barrier to her disclosing the abuse was not knowing what the outcome to a disclosure would be, lacking confidence that she would be moved. Practitioners told this review that maybe they could raise children's awareness of procedures and outcomes by making more creative use of "story books" to raise awareness of procedures and likely outcomes.

4.17. Motivations for telling identified in the research included: stopping the abuse; getting information and advice, emotional support, or medical help; or acquiring practical strategies to minimise harm. The peer support website analysis identified that posts often recommended that the young person should tell someone; teachers and school-based support were mentioned more often than other practitioners. This is perhaps not surprising as school practitioners are accessible to most school-aged children without others knowing and can be "sized up" overtime. Child C confided in a friend about the alleged abuse by the carer, who encouraged her to tell a teacher. The following day Child D also confided in a teacher but would not repeat what she had said to the social worker and police officer. Alongside the personal qualities of kindness, empathy, competence and being non-judgemental, duration of the relationship was a key component of trust for the study participants. Some practitioners, for example social workers, or those from other agencies with specialist safeguarding roles, are trained and experienced in building rapport quickly given the nature of their roles in needing to establish trust with young people who have made, or are thought likely to make, disclosures. Teachers, like social workers and youth workers, were viewed by study participants in a more holistic way, rather than, for example, doctors for medical support.

4.18. One of the practitioners at the mapping meeting told this review that looking back, they had known that there were weekly CAMHS phone calls to Child C; a statutory review, and some home schooling and some school attendance and whilst they recognised these could not entirely replace actual face to face visits and direct work with the children, they had been falsely reassured that if there were

[14] Cossar J et al (2013) Op cit page v

something to disclose the children had people to talk to. However, there is no evidence that the barriers to the children disclosing described above were explicitly considered. In addition, the research[15] shows how relatively rarely agencies receive reports of sexual abuse at the time (10% of cases), or soon after (25% of cases). Many victims of any form of sexual abuse may wait until they are adults to confide in someone and at least 20% of adults abused as children never tell anyone. Disclosures about abuse by an adult are more likely than abuse by a child but, even then, a third of people never tell anyone about it. As in this case, older children are more likely to disclose abuse than younger children who may not have the words to describe or explain their experiences to an adult, and/or they may not recognise that they are being sexually abused.

Summary of learning: Children's voice and disclosing abuse

- Children are more likely to provide views honestly if they feel safe and have a strong relationship with the practitioner and, especially for younger children, if techniques of direct work are used which avoid a direct question-and-answer approach.
- Children feeling safe to be honest about their lived experience may include a need to be seen alone and outside the placement. Practitioners need to find ways to make this an appealing prospect to children and an expectation for both carers and children
- Beliefs that placements are "settled" and perceptions that carers are capable can provide false reassurance that children are safe and well cared for.
- The importance of practitioners being mindful of what research indicates are the five main barriers to children making disclosures; emotional discomfort, worry about the family knowing, underestimating the seriousness of the concern, threats and fear of not being believed.
- The importance of trusting relationships when children make choices about who to confide in and disclose abuse to.
- Agencies become aware of only a third of child sexual abuse at the time of its occurrence or soon after. Practitioners knowing that children are in contact with several practitioners can give false reassurance that if there were something to disclose the children had people to talk to

See recommendation A

Theme: Recognising and addressing children's vulnerability to sexual abuse

4.19. There is strong evidence that Child Sexual Abuse (CSA) is associated with an increased risk of a range of adverse outcomes, although the impact of child sexual abuse on victims and survivors can vary significantly, influenced by such issues as how long the abuse lasted, an individual's resilience, and the support they receive. The impact is not always easy to distinguish from that of other adverse childhood experiences. However, the impact of CSA can be lifelong and affect physical, emotional, and mental wellbeing, relationships, socioeconomic outcomes, and vulnerability to revictimisation.[16]

[15] 2019 Crime Survey for England and Wales cited in Karnsa K & Kelly L(2021) ibid
[16] (2020) The multi-agency response to child sexual abuse in the family environment Prevention, identification, protection and support Ofsted

4.20. Research surveys covering England and Wales suggests that at least 15% of girls and 5% of boys experience some form of sexual abuse before the age of 16, including abuse by adults and under-18s. International studies have shown that prevalence of almost every kind of sexual abuse – by adults, peers, family, acquaintances, and strangers – increases with age between 15 and 17. The significant majority of perpetrators and victims are male and female respectively. Penetrative abuse is less common than other forms of sexual abuse, but it is more likely to be repeated and tends to be committed by people already known to the victim, with family members being more common for girls and authority figures for boys.[17] According to responses to a recent survivor survey[18], child sexual abuse in the family environment (family member or someone trusted by a parent) comprises around two thirds of all child sexual abuse. Typically, this begins at a much younger age often around the age of 9 years old.

4.21. Nationally, there were 1,970 children subject to child protection plans under the category of sexual abuse (4% of all plans) at the end of March 2020. Whilst the number has remained relatively stable since 2014/15, there has been a significant reduction in proportion over the last 20 years. Reasons for this include: children abused in the family being placed on a plan for another type of abuse (such as neglect or emotional abuse) which could dilute the focus on CSA, and children being placed in the care of a local authority rather than being on a child protection plan.[19]

4.22. Proportionally then, practitioners are less used to working with families where CSA is the primary risk. A recent joint inspection of police social care probation and health services response to sexual abuse within a family environment in 6 local authorities[20] also identified that there is too much reliance on children to disclose verbally, and that practitioners lack the confidence, knowledge and skills to talk about sexual abuse within the family environment (family member or someone parents' trusted). The Children's Commissioner shared these concerns and added practitioners' ability to recognise potential signs of CSA.[21] This all results in the risk of sexual abuse not being identified and therefore not being a sufficient focus of service intervention. In addition, inspectors saw very little evidence of public awareness raising about the risks of sexual abuse in the family environment: preventing sexual abuse within families was not seen to be a priority for local safeguarding partnerships.

4.23. There is no evidence that a Child Sexual Exploitation (CSE)[22] risk assessment using a local tool was completed despite the Independent Reviewing Officer suggesting one for Child C in March 2019. Nor any evidence that the possibility of CSA was considered. The former is understandable as both children exhibited very few of the classic signs of vulnerability to CSE, for example going missing,

[17] Karnsa K & Kelly L (2021) Scale and nature of Child Sexual Abuse; review of evidence Centre of expertise on Child Sexual Abuse
[18] Children's Commissioner 2015 : Protecting Children from harm: a critical assessment of child sexual abuse in the family network and priorities for action
[19] 2020 Ofsted ibid
[20] (2020) The multi-agency response to child sexual abuse in the family environment Prevention, identification, protection and support Ofsted
[21] HM Government (2021) Tackling Child Abuse Strategy
[22] CSE occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity: a) In exchange for something the victim needs or wants; and/or b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. (Working together 2018)

and disengagement with education. This maybe partly why the risk of CSA was not considered, especially as potential vulnerability from a foster carer required practitioners to "think the unthinkable" of someone who has been assessed as suitable to protect and care for children. Given that children so rarely disclose CSA it is important that practitioners are alert to the possibility so that opportunities to identify it are maximised, including facilitating disclosure (see theme "Children's Voice").

4.24. The Centre of Expertise on CSA has recently published a signs and indicators template[23] which explores emotional, behavioural, and physical signs that may indicate CSA. It is not intended as a diagnostic or assessment tool, more an exploration about whether there may be potential cause for concern, including circumstances which might put children at more risk. It is intended as a dynamic tool to be updated over time and explicitly recognises that the signs and indicators it identifies can be indicative of other kinds of trauma or abuse. However, both children had some characteristics and experiences that could have made them more vulnerable. These were: for both children, their exposure to chronic neglect and the trauma of their father's death by suicide, for Child C: previous victimisation (twice at school); needing help from CAMHS to reinforce that what happened to her was an assault which was not her fault; self-harming; a significant increase from a healthy weight in 2018 to an unhealthy one in 2021;[24] a need for a toilet pass at school due to frequent urination, for Child D: the GP was contacted regarding bedwetting in October 2018 and for a suspected urinary tract infection (UTI) in Jan 2019. The incidence of bedwetting in 2018 was unusual at the time for Child D, but the potential causes offered by the foster carer at the time were plausible. The carers also exhibited behaviours that might indicate vulnerability for the children. These were, for the male carer: touching in a way that makes child or observer uncomfortable (the report from sibling); being overly involved in the intimate care of the child (statement that he would have helped Child C out of her wet clothes after a self-harming incident, had no-one else been present); lack of boundaries (inappropriate comments about physical attributes of Child C). For both carers: gatekeeping contact with the child (always being present at medical appointments even when the practitioner suggests seeing the Child C alone). Other factors include: social isolation which was a consequence of the Covid pandemic, which also limited practitioners' face to face scrutiny of the carers, and contact with the children during the second half of their placement; and absence of a strong relationship with a birth parent regularly in contact with them. These are examples known to the review, other signs might have been apparent had such a tool been used by a multiagency group who knew the children AND the foster carers well.

4.25. Leicester safeguarding partnership does have a (child) Sexual Abuse policy.[25] About half of it focuses on how to a respond to a disclosure, which we know is not common. It does include a short list of signs and other factors which is less useful than Centre of Expertise (C of E) template in that almost all of them could be indicative of other concerns than CSA. Neither the local nor the national procedure explicitly mentions that foster carers (as well as adoptive parents and Special Guardians) have been known to sexually abuse children and the consequent importance for children in care of working with the fostering social worker to assess risk and protective factors and steps to increase scrutiny (see theme: Assessment of foster carers, support, monitoring and matching. Children are

[23] https://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/signs-indicators-template/
[24] there is no evidence of the weight gain being discussed with her before 2021, and then in terms of her ambition to join the army and a recognition by Child C that she needed to eat more healthily and exercise more rather than considered as a risk factor
[25] https://llrscb.proceduresonline.com/files/sexual_abuse.pdf

not abused because they are vulnerable, they are abused because the perpetrator has the wish and ability to take advantage of this. All children are potentially vulnerable due to their age and the power imbalance with adults. For those in foster care, the foster carers are in a good position to shape their world, especially in the home, and how they engage with others.

Summary of learning: Recognising and addressing children's vulnerability to sexual abuse

- Features of this case echo research findings that there is too much reliance on children to disclose verbally, and that practitioners lack the confidence, knowledge and skills to recognise the signs of and risk factors for sexual abuse
- It is hard for practitioners to "think the unthinkable" that foster carers might sexually abuse children and local policies do not acknowledge this either.

See recommendations A and B

Theme: Assessment of foster carers, support, monitoring and matching

4.26. To become approved as a foster carer requires an assessment by a fostering social worker. This requires several statutory checks including personal references and consideration of applicants' childhood experiences, health, current and any previous relationships with partners, and experience, and skills in caring for children. Completed assessments, including the results of statutory checks, are then presented to the agency's fostering panel which is made up of people with relevant skills and experience, most of whom, including the chair, are independent of the agency. The panel will make a recommendation to the Agency Decision Maker about whether the applicants are suitable to be foster carers, and what the criteria should be (number and gender of children, age, short term/long term/respite).

4.27. Mr and Ms X made two applications to foster, once in 2016 which was unsuccessful (the assessment ceased with the couple's agreement), and once in 2017 when they were approved to care for one child, two if siblings short term and respite 0-18 years. For the unsuccessful application, it was recognised that both had relevant work or volunteering experience and some understanding of the fostering task, and a type of motivation not uncommon in applicants (they had friends who were foster carers and said they had seen the joy the placements brought them and the children and the satisfaction from seeing the children make progress). However, the social worker had concerns about the male carer's engagement with the assessment, for example: not doing reading requested; being dismissive or reluctant to complete necessary paperwork; and using humour inappropriately as deflection. During preparation for fostering training, he was observed to talk over other people, considered more likely to seek advice from other foster carers than professional sources, and used outdated language about equality and diversity issues. These are not necessarily a barrier to fostering if applicants are able to reflect and change, however the fostering social worker identified that the male carer was very defensive when challenged. This kind of behaviour suggested he would not be able to work well as part of a team or be willing to take advice from practitioners if it did not match his own views. This is also a particularly unhelpful characteristic in the primary carer; Ms X was in full-time employment at the time of both applications, and it was always the couple's intention that he be the main carer. This is unusual, but all local authorities have couples where the main carer is male, including same sex couples, who provide excellent care to children.

4.28. According to Ofsted statistics only 39% of applications to all fostering agencies in England and Wales were approved in 2018-19, 60% were withdrawn, two thirds by the applicant and one third by the agency and 1% were rejected by the agency.[26] Therefore, it is not unusual for applications to result in applicants not being approved. What is extremely unusual in this case is that subsequently a person in a position of authority wrote to the local authority recommending the couple as community minded "good people" and stating that they wanted to be re-assessed. A Service manager sent a further letter to the couple explaining the reasons why their assessment had been ceased, followed by a home visit. In spring 2017 the couple sent a letter stating they had been misrepresented/did not fully understand the reasons why they had been deemed unsuitable. They expressed a wish to be reassessed. It was decided that a different social worker from the first should make a visit regarding during which assessment questions included the main areas where there had been previous concerns. Subsequently a meeting involving that social worker, the team manager and service manager then considered the concerns and strengths (which included a reference from a current foster carer in the original application). It was agreed to offer the couple the opportunity to repeat the training and for a full re- assessment to be undertaken by the second social worker. The change in social worker is good practice as it is important that the application process is *seen* to be fair, as well as being fair.

4.29. The couple's second application was successful, without evidence of the previous concerns, and with positive examples of engagement in the process e.g. both applicants showing good understanding of the needs of foster children and empathy with them and their parents, appropriate contribution of their experience and asking relevant questions. All statutory checks were undertaken, and appropriate family and personal references were sought. These either positively supported their application or raised no concerns. The 2nd assessing social worker explored the original concerns with the couple during the assessment.[27] However, there was no information about the previous unsuccessful assessment in the papers that went to fostering panel and the ADM, for reasons that are not known. Had the panel members and ADM known about the previous unsuccessful application they would have wanted to understand the issues and satisfy themselves that they had been resolved before making a recommendation and decision respectively, that the couple were suitable to be foster carers. They would have likely been mindful that the behaviours might only have been supressed for the duration of the assessment, or re-appear when the carers were under stress, rather than be resolved entirely. They might have made additional recommendations/decisions; for example, that (rather than waiting up to the full maximum of 12 months stipulated in the regulations), the couple have an early first annual review, which included specific feedback from others working with the children (for example school and/ or CAMHS) or for specific training to be completed. They might also have made some observations about cautious matching and additional support/monitoring.

4.30. Whilst both the intervention of a person in a position of authority as an advocate and the offering of a second assessment is very unusual (this is the only time this has happened in Leicester) the process to consider the representations by the third party and the couple were robust. What was not

[26] Ofsted 2020 and Cleaver H et al 2020 op cit
[27] Ofsted inspection of Leicester Children's services in 2021 concluded that recruitment and assessment of foster carers and adopters is thorough, timely and analytical.

robust was the lack of information in the second assessment about the unsuccessful application as described above. As a result of this case, amendments are being made to the local social work practice standards to ensure that full information about previous assessments and concerns are addressed in subsequent assessment and reports to fostering panel and Agency Decision Makers. While the process followed to consider whether a second assessment should be offered was robust. However, this is not currently supported by written procedures and changes will be made to the electronic fostering procedures in the next annual update.

4.31. When children need a foster placement a description of their needs is prepared for matching against what foster carers can offer. Ideally there would be a choice of carers. A court had approved a care plan for children C and D that involved long-term fostering. Mr and Ms X were not approved as long-term carers; their ability to care for children for the rest of their childhood had not been assessed. When Child C and D needed a placement Mr and Ms X were the only local carers who had the capacity to take siblings, and the children were placed on the basis that they would be re-assessed if the placement seemed viable long term. Local placement promotes continuity of education (the children were able to stay at the same schools) and facilitates contact with family members. Whilst Mr and Ms X were very new carers, the needs of the children were not untypical of many looked after children of their ages and so experience would not be a barrier. The expectation would be that their supervising social worker would make sure they had appropriate support while the children's social worker made sure the children had the right support and that the two social workers worked together to achieve this.

4.32. To minimise the risks of sexual abuse of children by volunteers or staff, recruitment processes need to include appropriate selection processes. However, it is also necessary to manage organisational processes so that the possibility of inappropriate or abusive behaviour developing or occurring is minimised. The study describes Finkelhor's (1984) original process model of sexual abuse alongside consideration of situational crime prevention theory as being a useful way to consider organisational measures which might increase protection from an individual motivated to sexually abuse children. As well as rigorous vetting and screening, measures would include reducing permissibility of inappropriate behaviours and increasing risk, and perception of risk, of detection.[28]

4.33. In a fostering context this would include several elements. For all carers these include: building trusting relationships with children and seeing them in circumstances where they feel able to communicate freely, including the carers knowing of an expectation that this would be alone and outside the house; training, especially safeguarding, safe caring and anything specific to the needs of children placed; regularly updating the safe caring policy for the household; regular supervision; unannounced visits; seeking others views to inform annual reviews (e.g. children's social worker and schools); completion of the Training Support and Development Standards (TSDS) within the first year of fostering; prompt addressing of any concerns, including use of a standards of care/concerns process or referral to the LADO for allegations involving potential safeguarding concerns; and Post Allegations Reviews being presented to fostering panel and ADM; and scrutiny and quality assurance of assessments by the fostering panel and Agency Decision Maker. For couples the individual role and voice of *both* carers should be visible. As described in the remainder of this section some of these measures were not used effectively or at all with Mr and Ms X. In addition, the

[28] Erooga M et al ibid

Covid pandemic had a particular impact on the supervising social worker's oversight. Fostering records show that from 23/03/20 social workers began working from home with Skype and Teams calls to carers starting weekly/fortnightly. Home visits could be made for concerns around safeguarding or fragility of placement; this was seen as a stable placement without safeguarding concerns so the foster service made no visit until December 2020. There was also no face-to-face training for foster carers.

4.34. Changes in staff can affect the effectiveness of oversight and scrutiny. In Leicester the staff that complete fostering assessments are not the same as the staff who supervise social workers. The supervising social worker was not aware that there had been a previous failed assessment, nor therefore about the issues that had caused it. The 2nd assessing social worker did not mention it during the handover (which included a discussion of the expectations of carers) for reasons that are not known, although it was suggested to this review that perhaps the positivity of the information gathered/received during the following 12 months had diluted the original concerns. Whilst the information was on the carers' record it was not easily visible. This was for two main reasons. Firstly, because it was not in the Form F assessment which had resulted in approval, which is a key document for any new supervising social worker to read. Secondly because chronologies start at the point carers are approved due to the way the electronic record only picks up information from the current "pathway", which did not include the previous closed assessment. The latter reason is likely to be unique to this case as there has been no other unsuccessful full assessment which has been followed by a successful one in this fostering service before or since this case. This meant that the supervising social worker was unable to consider any support and training that might minimise the chance of a recurrence of the concerns, nor would they recognise that further similar concerns were not new, they were part of a pattern.

4.35. In April 2020 there was a change of Fostering Team Manager when the supervising social worker moved to the kinship team, and then a new supervising social worker identified back in the mainstream fostering team in September 2020. However, records show evidence that the new and the old supervising social worker had a conversation about the mapping meeting, the concerns discussed and actions to be undertaken as part of the handover arrangements. This was good practice.

4.36. Practitioners told this review that the male carer was an "imposing" figure who was very forthright and direct. That is not necessarily always a bad thing although some situations require a more tactful approach. What is concerning was how he was observed to take over conversations, especially those involving his partner, whose voice was therefore less visible. Several practitioners described him as "belligerent" when caught by surprise by events. To a degree these behaviours are a continuation of the concerns seen in the first assessment. The study of SCRs previously referred to includes examples of (usually) males gaining inappropriate level of power/control through belligerent behaviour.

4.37. First annual reviews are an opportunity for all parties to take stock of how the fostering household has adapted to fostering, to consider whether the strengths and vulnerabilities identified at approval remain relevant and whether areas for development have been addressed. Since 2019 a fulltime FIRO has recruited to replace the previous system of annual reviews being conducted by a team manager. This has provided extra capacity, continuity of oversight and independent scrutiny since the officer is located within the same service as the IRO's. The FIRO is currently required to conduct

a desktop review of the assessment, case records, and chronology 6 months after approval to make sure there are no concerns about the foster carers; any concerns result in an early annual review. The continuity of oversight provides a good opportunity to identify any patterns of concerns and fostering staff have recently completed training on identifying manipulative and other behaviour that is designed to keep practitioners at a distance. There are also regular meetings between the LADO, the IRO manager and the FIRO to identify any emerging themes.

4.38. The first annual review for Mr and Ms X was conducted in April 2019 by one of the team managers acting as Reviewing Officer. They were not aware of the first failed assessment because it was not easily visible on the record as described above. The review identified the need for an unannounced visit and to update the safer care policy. In addition, the carers had not completed their Training Support and Development Standards (TSDS) which should have been done within 12 months of approval**.** This review was told that this was because the couple had technological problems with access to the relevant emails and training site. The current process of desktop reviews at the 6-month approval stage would provide an opportunity to ensure that any barriers in getting started on the TSDS have been resolved. No report about the first annual review was taken to the fostering panel for oversight as it should have been, as this was not the policy of the service at the time, despite it being a statutory requirement.[29] Had the review been presented to panel, members would have highlighted the lack of an unannounced visit and non-completion of the TSDS and the lack of an updated and individualised safe caring plan. Current practice is to present first review to panel; however, panel members are only assured that safer care plans are up to date they do not see them. Fostering staff told this review they could see the merit of safer care plans being shared with panel, as by this stage in a foster carer career the annual update should reflect their experience and the needs of any individual children placed.

4.39. The second annual review was conducted in April 2020. The review included the supervising social worker's and carer's feedback but not information directly from the children, school or CAMHS. Neither did it include feedback from the children's social worker, despite this being requested.[30] The FIRO identified that the Safer Care policy had been updated but not to reflect the needs of the children in placement and that the couple had not done safer care training. It is not known which records the FIRO read in preparation for the review as practice then did not include reading the case records or the Form F assessment as it does now, due to learning from this case review. Actions from this foster carer review included the supervising social worker doing an unannounced visit, collecting written feedback from the children's social worker, the children to complete consultation forms, and both carers to complete the safe caring document, and first aid and managing challenging behaviour courses.

4.40. The aim of the Safer Care Plan is to enable foster carers to demonstrate how they propose to make their home as safe as is reasonably practical, both emotionally and physically, for any child placed and for the carer and their family. The Centre of Expertise on CSA template previously referred to does list a number of carer behaviours the avoidance of which that are normally covered in the safe

[29] The Fostering Services (England) Regulations 2011 regulation 28 (5)
[30] More effective arrangements to ensure the views of social workers and IROs for all children placed in the year prior to a review are provided since the appointment of a permanent FIRO. Their reports are not signed off until this information is available and if it is not forthcoming the matter will be escalated.

caring plan[31] required for all foster carers. Safer care plans which have been signed by the carers and the assessing/supervising social worker should be developed as part of the assessment process and in place for all approved foster carers. Safe caring policies should be reviewed/updated whenever carers have a new placement, for each annual review, and when new risks emerge Even if the starting point for drafting these is a standard template, they should be individualised to reflect the circumstances of the foster carer household and updated annually. It is good practice to update them to reflect the (changing) needs of children in placement, and to consider involving all children in the household in shaping their content. The safer care policy was updated in May 2019, as recommended by the first review, but it was not individualised to the needs of the children.

4.41. Safer Care plans are a useful discussion tool to help carers identify appropriate and inappropriate behaviour, and for the social worker to call them to account if there are potential breaches. For example, these include agreements about appropriate dress in the home and appropriate showing of affection, how and where, and personal care. As well as protecting children they also minimise the risk of carers getting themselves into situations where (unfounded) allegations or concerns are more likely. An individualised safer care plan for Child C and D over time, should have included management of: Child D's bedwetting including personal care regarding this, Child C's cutting; and consideration of the implications of the sexual assault of Child C; showing of affection; comforting the children when they are upset. The safer care plan was not updated to include any of the children individual needs until March 2021, this then included a reference to managing Child C's self-harm. The children were not consulted about the content. Family placement managers told this review that the use of safe caring policies could be strengthened by including children in future, especially if there had been any concerns. Currently annual foster carer reviews do not proceed without there being an updated safer care plan. The need to ensure these have been personalised has been discussed in team meetings. The impact of this could usefully be tested by an audit of safer care plans.

4.42. Foster care national minimum standard 21 indicated that supervising social workers should conduct at least one unannounced visit to foster carers every year. Some local authorities require a minimum of two unannounced visits per year. During the whole period covered by the review there was only evidence of one unannounced visit completed in the required manner (involving access to the house and discussion with at least one carer, and ideally seeing the child). This was in March 2020. The first one was attempted in September 2018 when the supervising social worker met carers in the street coming back from a PEP meeting, so there was no opportunity for discussion in the home with both carers, The next attempt was in October 2018, which was not successful as the carers were out, and should have been repeated. The carers could anticipate the successful visit in March 2020 as it was just after the bath incident and not long before an annual review was due. The final unannounced visit in December 2020 was conducted on the doorstep visit due to Covid restrictions using the carer's mobile phone to undertake the expected inspection of the carer's property. Unannounced visits are included in the fostering services quality assurance framework, which the FIRO produces monthly for senior manager scrutiny. Prior to the pandemic the rates of achievement were over 90%, but as doing one unannounced visit annually is a minimum standard there is scope for improvement.

[31] The purpose of the Safer Caring Plan is enable Foster Carers to consider potentially abusive or risky situations which may arise in the foster home, and to set out the arrangements within the foster home for minimising any such risks.

4.43. The carers were approved as "short term" carers. This does not mean a certain period of time; it means as long as the placement is needed pending decisions about "permanency planning" for the child. Permanency planning should start at the 2nd statutory review, i.e. four months after a Child becomes looked after and be achieved as soon as is practicable. The only possible option for these children, given their age and some connection to birth family members, was long-term fostering,[32] either with the current carers, or with alternative carers. In this case their placement was not endorsed as potentially long term until their fourth statutory review in September 2019, followed by a permanency (matching) meeting in October 2019, which is 18 months after the children had come into care. It took a further 3 months for the necessary re-assessment of the foster carers as potential long-term carers to be done. Panel deferred consideration due to wanting to see the 2019 annual review documents and then it took another 3 months for there to be a slot at panel which was held in April 2020. The papers presented to panel and ADM did not include any details of the concerns which had accumulated by then. This meant that neither panel members nor ADM had the opportunity to consider whether these meant the carers were still suitable as foster carers either for these children or any children. In practice the concerns that had been identified by April 2020 probably would not have prevented their ongoing approval especially as the children were generally perceived to be "settled". However, there would have opportunity to make recommendations/decisions about any support, training and scrutiny required, including an early annual review, either within the service or by being brought back before panel. Even without knowledge of the concerns, there should have been challenge to the service about not ensuring there was an unannounced visit since October 2018 and updating the safer care policy to reflect the children in placement's (changing) needs

Summary of learning: Assessment of foster carers, support, monitoring and matching

- Where carers are not successful in their first assessment it is important to keep the reasons in mind if they are subsequently approved and address promptly any emerging similar concerns
- Organisational processes to minimise the possibility of inappropriate or abusive behaviour by foster carers are important. They include; building relationships with children and seeing them outside of placement; ensuring carers do relevant training, including safeguarding and safer care training; updating safer care policies according to the needs of the children placed; unannounced visits; seeking the views of other practitioners and family members during reviews, and addressing any concerns promptly.
- Safer Care plans are a useful discussion tool to help carers identify appropriate and inappropriate behaviour for individual children placed as well as any child, and for the social worker to call them to account if there are potential breaches.
- Fostering panels provide an important layer of additional scrutiny, any presentation to panel for whatever reason (all assessments and reassessments, the first annual review) should clearly identify any standards of care concerns, previous and current, as well as any allegations and describe how they have been dealt with

[32] Options which were not possible include a return home where this is safe, alternatively adoption for very young children without strong connections with their birth family, or a placement with kinship carers.

See Recommendation C

Theme: Management of incidents, and concerns, complaints and allegations about foster carers

4.44. A recent study[33] of Serious Case Reviews (SCRs) involving adopters, foster carers and special guardians included cases where concerns and information recorded had not been subject to robust scrutiny and challenge. Concerns were identified in 14 out of the 39 fostering cases.

4.45. During the period the children were placed with the foster carers there were several concerns reported to the supervising social worker about the male carer, prior to the allegations which prompted this review. In December 2018 the school made a complaint about the male carer's "aggressive tone" when his request for a toilet pass for Child C due to a need for frequent urination during menstruation was initially refused. In addition, he removed Child C from school and the supervising social worker had to remind him that foster carers do not have authority to do that. In June 2019 the male carer displayed an "aggressive tone" when asked to collect Child C from school after she had been sexually assaulted by a pupil when school staff did not think it appropriate to explain why this was appropriate / necessary to explain over the phone. In early March 2020 the supervising social worker observed the male carer to make explicit comments about Child C's menstrual cycle in training. In March 2020 the male carer maintained, despite challenge from the supervising social worker, that it would have been appropriate to help Child C out of her wet clothing had her friend not been there to do it. Records show both incidents made the social worker feel uneasy.

4.46. The reported incidents reported to or observed by the fostering supervising social worker were each addressed individually with the carers by the fostering service. In practice they were always addressed with the male carer but not always addressed with the female carer, unless the visit was planned for that purpose, as she was otherwise likely to be at work. The aggressive tone incidents were seen as over-reactions when things were difficult. For the wet clothing incident, which came up when the female carer was not there, the social worker was uncertain whether the male was naïve or had an ulterior motive and the outcome, after a discussion with the IRO, was for further training and work on safe caring. This was the point at which the safer care policy was individualised for these children for the first time. This was not the first time that the IRO had suggested further work on safe caring. In September 2018 after discussions about Child C's suicidal feelings in a statutory review the IRO recommended that the supervising social worker should spend time with both carers talking in more detail than was appropriate at a statutory review about what is/isn't appropriate regarding support they can offer to Child C when she is upset or is seeking affection.

4.47. Since the allegations that prompted this review other concerns about the male carer have come to light. In 2018 the school described him as "belligerent" when he arrived to collect Child C from an induction day when she had left rather than waiting for him as expected. The CAMHS practitioner felt the male carer's reaction to being contacted about Child C was a bit "gruff" but the context was that parents/carers are often a bit frustrated if they have been waiting for a service and everyone was feeling a bit fragile due to the Covid pandemic. It is also unusual for a male foster carer to call

[33] Cleaver H and Rose W (2020) Op cit

a GP about a letter for Child C in relation to more frequent urination during menstruation. Whilst he was the primary carer, for couples that include a female it would still be more usual for the female carer to deal with such issues. This is the third reference to the male carer mentioning menstruation, with the other two making observers feel uncomfortable. During the police investigation a member of the community also reported having noted a physical "too closeness" of the male carer with the girls which they remembered once being aware of the allegations. During the investigations into the allegation that prompted this review another foster carer alleged that they had overheard the male carer using innuendos in front of their older foster child and referring to sex toys. The foster child present confirmed this and that the carer "told him off". The carer stated that she had mentioned to their supervising social worker that the carer was "touchy feely", this review was told that the carer thought the behaviour was poor taste rather than anything more concerning. There is no evidence that these concerns were recorded or reported to the relevant supervising social worker at the time.

4.48. Practitioners told this review that there was often an understandable context to each incident of "aggressive tone" behaviour, which was sometimes apparently motivated by concern for the child. This raises an interesting question about the threshold for what an understandable behaviour for a parent/carer at a stressful or frustrating moment was but not the kind of "professional" behaviour that should be expected from a foster carer. School staff told this review that one challenge for schools in considering this is that sadly they have become somewhat desensitised due to aggressive behaviour from parents. Fostering staff told this review that the male carer was challenged about those school incidents they knew about and he was told that he needed to be more careful about how he was presenting and that if he needed to off load, doing so with school staff was not the way to do it.

4.49. Practitioners also told this review that both carers seemed mostly pro-active in addressing the children's needs[34] and very engaged in key activities, for example the male carer would prepare for planned meetings, engage fully and take notes. Although this is what carers should do these behaviours gave some false reassurance, which was also a feature in another recent local SCR involving sexual abuse by a foster carer (Child A and B). All of this combined to create a situation where the carers were given the benefit of the doubt. The study of SCRs previously referred to includes examples of where carers were given the benefit of the doubt.

4.50. In mid-April 2020 the Fostering Independent Reviewing Officer 2 (FIRO) noticed the concerns reported to the fostering social worker whilst checking the care records in preparation for the carer's 2nd annual fostering review. She recognised that these resonated with some of the issues discovered through national SCRs. Accordingly, she raised this with the relevant service manager who invited the relevant child and fostering social workers and their team managers and the IRO to a mapping meeting held later in April 2020. This was good practice. In addition, the chair of the mapping meeting asked the children's and fostering social workers between them to: gain the children's perspective (which was sought and shared by the children's social worker), review the Form F to check for gaps in assessment (none identified) and children's case notes and contact other agencies e.g. schools to identify whether there were any other concerns.

[34] e.g taking Child C to the GP when she had suicidal thoughts, requesting a re-assessment before she was discharged from CAMHS, supporting her to make a formal complaint about the sexual assault in school, driving a considerable distance to take the children to their father's funeral

4.51. The mapping meeting was the first time that all the concerns, including the reasons for the first unsuccessful assessment, known to the social workers were considered collectively by a group of social care practitioners. Records suggest that the children's social worker was not aware of any of the concerns about the male carer until then. Social work managers told this review that the children's and foster carers' records are somewhat disconnected without key information being reflected in both; the notes of the mapping meeting were sent to all parties present but do not appear on the children's records for reasons that are not known. There was no direct representation at the meeting from any other agency including the schools. It has since been recognised that this would have been useful. Schools have the most contact with the children and were best placed to notice any past or future changes in behaviour or draw out any concerning comments, although contact would have been affected by the UK having recently gone into lockdown, which for Leicester meant they were not physically in school between March and September 2020, and between January and March 2021.[35] Research[36] tells us that school staff are the practitioners' children are most likely to disclose abuse to as proved consistently the case for Child C (the [redacted] and sexual assault incidents in school) and for both children in March 2021 soon after they were able to return to school in person. The LAC nurse was not invited either; she could have provided information about the children's health.

4.52. Practitioners told this review that whilst there was a level of unease, there was nothing concrete about which to take action. The children appeared settled, with evidence that Child D had grown in confidence during the placement, and the carers appeared nurturing and provided appropriate activities and boundaries. The outcome of the meeting was that practitioners should remain "curious and vigilant", and directly address with the foster carers any behaviours or attitudes which were viewed as concerning, unhelpful, or not therapeutic. Several training courses were recommended[37]. These included Safe Caring, the role of the foster carer and Safeguarding for the male carer all of which should have been completed at an early stage in the carers fostering career. The first course was never completed and the second two only partially. The female carer had done a safeguarding course for her employment. There is no evidence of consideration as to whether this was sufficient transferable knowledge to the specific responsibilities of a fostering role. The children's social worker was tasked with doing some direct work with the children and to see them away from the placement. There was an assumption that, although she was only visiting every 12 weeks at this point, the social worker was best placed to undertake this work because of her role; there was no discussion about who had the best relationship with each of the children.[38] Neither happened because of Child C's reluctance to co-operate. Another foster carer was identified as a peer mentor but Covid restrictions and then the allegation prevented their involvement. More efforts were to be made to hear the female carer's voice as she was less visible partly due to being in employment, but also due to the male carer's tendency to assume the lead in any conversation.

[35] This was because although all looked after children were a priority for attendance, in practice decisions were made about individual children according to perception of the risk and consequences for the household of being infected. It was agreed that the children could be home schooled and they made good progress.
[36] Cossar et al (2013) Op cit
[37] Safer Caring; Safeguarding. Self-Harming – emotional wellbeing, Understanding the role of Foster Carers. Caring without Bias.Understanding trauma and therapeutic parenting
[38] Fostering managers told this review that discussion about who is best placed to engage with children comes up at meetings where placements are unstable or dispuption meetings after an unplanned ending of a placement, but that this is not always considered

4.53. No timescales were specified for any of the actions from the mapping meeting, and no review mapping meeting was scheduled. A new supervising social worker was to take up the actions for the fostering service due to a change in role of SSW1. Practitioners told this review that on reflection, and faced with a similar situation again, they would hold a follow-up mapping meeting to assess progress. This would have identified those actions that were not followed up

4.54. The carers 2nd annual review was scheduled and went ahead just before the mapping meeting as did the Fostering Panel which recommended a change in the carer's approval criteria to include long-term fostering and a long-term match for the children with the foster carers. Regulations state that annual reviews must be held within timescales. However, in these circumstances a further (early) annual review should have been conducted after the mapping meeting. As a result of this review, arrangements are in place to ensure that happens and that no case goes to panel in future until any concerns have been properly considered. The fostering panel and Agency Decision Maker were not aware of the emerging concerns about the male carer to be discussed in the mapping meeting. Reports prepared by the fostering social worker did not include details of these. One reason for this was that, although each of the incidents and concerns reported to the fostering social worker were recorded in sufficient detail for FIRO 2 to identify them when they read the records in preparation for the annual review, they did not meet the threshold of a (safeguarding) allegation, nor were they conceptualised as standards of care concerns so they were not visible without reading the case notes, and they were not entered on the chronology which would be available for panel to see. Family placement managers told this review that because of this review they have developed a standards of care/concerns process when there have been 2 or more concerns which did not meet threshold for LADO and that they have undertaken an audit of all the carers this applied to. Whilst training has been given to ensure that fostering social workers know to add concerns to the complaints tab on the electronic recording system this is not an intuitive approach which could still leave gaps. In addition, there are still challenges for practitioners in deciding when a low-level concern about, for example, a foster carer's remark or attitude to being challenged, is significant enough to record or be worthy of discussion in supervision.

4.55. Practitioners told this review that on reflection, and faced with a similar situation again, they would postpone the fostering panel until after the mapping meeting. Concerns were not at a level which would have prevented the couple's ongoing approval as foster carers, however had panel and ADM been aware of the concerns they might have included such actions as agreed at the mapping meeting in their recommendations/decision. This would have put them on a more formal footing with a process to review them i.e. at the next foster care review, which might have been set before a further year to ensure the more urgent actions were carried out promptly.

4.56. In September 2020 a report from Sibling via Maternal Grandmother via Mother suggested that that she felt uncomfortable about the male carer's behaviour in a restaurant. Her mother reported that he was alleged to have made explicit comments about Child C's breasts and menstrual cycle and was seen to stroke Child D's back. The childrens' social worker spoke to the children in the placement. Had the children not been home-schooling due to the pandemic it might have been possible to have seen them in school. The social worker told this review they were reluctant to engage and did not raise any concerns. The social worker also told this review that her relationship with Child C deteriorated after this point, which could have prompted some useful reflection in supervision about

either how to address it or who else might have a better relationship. There is no evidence this was considered.

4.57. The social worker also spoke with Sibling who said that her mother had exaggerated her concerns. The carers told the supervising social worker that they did not remember the exact conversations and that stroking Child D's back was the kind of as a comfort as he would do his own children or stepchildren. Sibling telephoned the carers to apologise. It may be a relevant context that the carers were responsible for facilitating contact between the siblings and were providing Sibling with emotional and financial support when she was settling into her new accommodation as she was in conflict with Mother. This meant that the social worker did not have an easy opportunity to develop a relationship with Sibling and there was no family member in regular contact with the children who was independent of the carers' influence. The reasons why Sibling might say her concerns had been exaggerated should have been reflected upon, and a further mapping meeting at this point would have been useful. The FIRO did not become aware of these allegations until the allegations that prompted this review. Since this case the FIRO tracks cases where there have been concerns so would be more likely to become aware of them. However, this may not always be in a timely way unless they are specifically informed of concerns, although the FIRO told this review that due relationships with the IROs were strong and communication from them effective.

Summary of learning: Management of incidents, and concerns, complaints and allegations about foster carers

- Standards of care allegations should be visible in foster carers' records and appear in chronologies as part of reports
- Concerns about foster carers need to be considered cumulatively as well as individually
- It is not easy for agencies to identify the threshold between what might be understandable behaviour for a parent/carer at a stressful or frustrating moment, but which is not the kind of "professional" behaviour that should be expected from a foster carer.
- Actions from meetings which require children's views to be sought should consider who is best placed to seek them
- Where concerns have been raised or recognised just before an annual review, the annual review will need to be repeated once the concerns have been addressed.
- If family members subsequently withdraw or minimise concerns, they have raised it is important to reflect on why they might have done that
- Any concerns reported by a carer about another foster carer should be recorded and reported to the relevant supervising social worker.

See Recommendation C

Theme; Support for the children and information sharing within and between agencies

4.58. Mr. and Ms X reported that Child C confided suicidal thoughts to them in August 2018 (Child C confirmed to this review that she did not confide in Mr and Ms X, instead they searched through her belongings and found her diary). They took her to the GP the next day, who made a referral to CAMHs and arranged 10 sessions of counselling by Relate. The concerns were discussed at a

statutory review in September 2018. The school communicated with social worker and carers about the self-harm incident in school in October 2018 and put a safety plan in place, this included noting any concerning mood changes. The IRO visited the children in placement in October 2018 and subsequently fed back to the children's social worker that: the self-harming appeared to be superficial cuts which Child C was willing to let the female carer monitor to check there was no infection; that Child C had a counsellor: that social worker should do a safety plan/self-harm reduction complied with Child C and the carers; and to consider more direct work about self-harming from the LAC Nurse or CAMHS, recognising that there might be a long wait for CAMHS. There is no evidence that the children's social worker followed up these issues at her next visit in November 2018, other than agreeing a referral should be made to CAMHs. It is not clear who was to progress this. There appears to be no record of the GP being informed of the self-harm or being asked to consider a referral to CAMHS until the referral that was made in March 2020. By March 2019 it was reported to a statutory review that there were no recent reports of self-harm, that Child C could confide how she was feeling to her carers and the carers had no current concerns. The children's social worker had a conversation with CAMHs who advised that there was no need for CAMHs currently but that a re-referral could be made if Child C showed any signs of low moods or self-harming.

4.59. After the children's father died by suicide in May 2019, the school nurse saw Child C face to face she told she had a positive relationship with the carer. The school nurse completed a baseline health assessment, and, having consulted the CAMHs Professionals Advice line, planned to provide to complete work around self-harm, resilience, and risk-taking behaviours with Child C. By the end of June 2019 school nurse involvement ceased after 2 sessions as there were no more reports of self-harm, and on the basis that the LAC nurse would continue to be involved.

4.60. A multi-agency meeting involving carers and key practitioners was promptly convened after the episode of self-harm in the bath incident to devise a safety plan. In February 2020 the GP made a referral to CAMHS. This was received in early March 2020 and an initial assessment was conducted within expected timescales,[39] over two sessions in mid-April 2020. A total of 14 sessions with Child C commenced promptly and continued until September 2020. The involvement remained open but without further planned sessions, at the carers request, as they were worried that she might relapse. Child C was discharged from CAMHs in January 2021, due to improvements in her mood having been sustained.

4.61. After a peer sexually assaulted her at school Child C engaged well in specialist weekly counselling sessions. Records shows she was supported to change her mind about pressing charges by the counsellor and carers and about issues of consent by CAMHs. The counselling did not start until September 2019, which was 3 months after the assault, because there was a waiting list.

[39] Where children are put on a waiting list for treatment, CAMHs has recently started offering a short group-based psychoeducation intervention for parents and carers This group is provided as a waiting list intervention. The group is completed over six weeks and three sessions (and is currently delivered online). As well as enabling CAMHs to provide input to carers around caring for children who have suffered significant adversity, the group also means CAMHS clinicians may spend more time in direct contact with foster carers and parents, and any concerns raised about a carer or parent can be passed on to the case-holding clinician of a child.

4.62. The children each had a Single Assessment completed when they were admitted to care in 2018. Assessment information being up to date and including information from other agencies is important to inform the care plan. Child C's assessment was partially updated in June 2019 after the peer sexually assaulted her. Reports to statutory reviews partly fulfil the function of re-assessment, and this practice is supported by prompts from the electronic recording system, but this is not the same as a comprehensive holistic assessment of the child's needs which can change rapidly particularly during adolescence. There is no local guidance as to when it is appropriate to complete a further Single Assessment.

4.63. Mostly information sharing between and within agencies was effective. However as previously noted, until the mapping meeting the children's social worker did not know about all the concerns about the carers. The supervising social worker was not aware of the peer sexual assault which the school reported to the police, the child social worker and the foster carers until the male carer informed them the following day. Carers should keep their supervising social workers informed but children's social workers should not rely on this for significant incidents. The IRO does not have access to the foster carer's records so is not able to review their history as part of their role to monitor the delivery of the care plan and in this case could not check for themselves what action the fostering service was taking after the mapping meeting. This latter could be argued to be the role of the FIRO, but there is no evidence of the FIRO tracking actions after the mapping meeting either.

4.64. After Child C made the allegation which prompted this review, in the absence of the children's social worker, a duty social worker informed the primary school not to allow the carers to collect Child D and that they would collect her once a placement had been found. There was no further communication until the duty social worker arrived at 5.30pm. Social workers would be more familiar than schools with the length of time it takes sometimes to identify a placement and the school told this review they would have appreciated an update at the end of the school day to be aware that the carers had been informed. An update would also have been helpful because staff may have to change personal arrangements to stay on to supervise children.

Summary of learning: Support for the children and information sharing within and between agencies

- Roles and responsibilities of different practitioners when children are fostered need to be clear, there are always two social workers and two reviewing officers, one of each for the children and fostering role respectively.
- Key information about children and carers need to appear in both sets of records
- If securing placements for children is going to be delayed beyond the school day it is helpful to update staff as they may have to change personal arrangements to stay on to supervise children.
- Single Assessments should be updated to reflect changes in needs, risks and circumstances. Better practice would be supported if local guidance was updated to give social workers a steer on when this should be done

See Recommendation D

5. VIEWS OF CHILD C AND GRANDPARENT

5.1. Child C described being in a difficult place when she was first placed with Mr and Ms X and she was not feeling very communicative with social workers. She was, and is still, not keen on "chit chat" and at the time did not recognise "chit chat" as attempts to build a relationship. Child C feels that relationship building would be better done more naturally as part of another activity, for example collecting children and young people from school, and that it was important that children had time with social workers on their own when they had brothers or sister in the same placement.

5.2. Child C remembered being asked about going out from the placement when the social worker visited but, even when she was unhappy and after the abuse had started, she did not think there was any point because she would not have felt able to say what was happening to her. The main reason for this was that she needed certainty about what would happen, especially being confident that she would be moved to another placement. Previous experience in the placement made her doubt this would happen. Child C said that practitioners told carers she was "unhappy" they were either dismissive ("its just about pushing the boundaries") or upset and quizzed her.

5.3. Child C told this review that if the social worker had asked more probing questions about why she was unhappy maybe she would have said, but probably not unless she had certainty about the outcome. Managers reminded this review that in another local case a barrier to disclosure had been that the child feared they would be separated from their sibling. Child C said another problem was always being seen by SW or IRO in the placement when she was conscious that even if outside the house or in a private room the carers were not far away.

5.4. When Child C told someone about the abuse it was a friend. She didn't really want to tell anyone else, but she did because her friend's mother was a social worker and she explained what would happen, including that she would move placement. Her friend encouraged her to tell school staff, it took her a few days before she felt able to do that.

5.5. The Independent Reviewer and Child C talked about other ways to get help with abuse and find out what would happen if a child disclosed it. Child C was aware of Childline but she thought it was for emergencies and other "big events". She told us how for children being abused "you live it" and come to believe it's not a big deal and that no-one will believe you. She didn't see it as the kind of thing to report to Childline. We talked about ways of making it easier for children to disclose abuse, about the benefits of hypothetical conversations "my friend has this problem, what would happen if, what advice would you give her etc" Children might need time to tell their story gradually so need to come back to this more than once. Child C described this as having a sort of Ask for Angela for children in care to indicate there was something they needed to share (but which might not come out in one go so they needed to be patient). Practitioners recognised the value of getting young people's views on what might help them to share any concerns about placements and that this would be a useful outcome from this review.

5.6. Child C described her social worker as good at getting things done when she asked although the one thing she would have liked which didn't happen was contact with her paternal grandparents. This also was one of the main things that Paternal Step Grand Mother (PSGM) mentioned. She and Paternal Grandfather had no contact with the girls while they lived with Mr and Ms X. PSGM felt it was important that the girls settled in their new placement, but the grandparents would have liked

contact with them. PSGM knew the girls were having very limited contact with their mother. She felt this should mean children should be kept in touch with the rest of their family and that this offers them some protection of family members to confide in. Without this PSGM thought they were quite isolated. PSGM told this review that no-one ever spoke to them about having contact, and that if there were reasons why social workers thought contact was not a good idea no-one ever explained these to them. However, records show that the social worker made attempts to contact PSGM about having contact with the children from April 2019 at Child C's request. This did not proceed because of a combination of PSGM's initial reluctance for it to be supervised due to concerns she might undermine the foster placement, and then difficulties contacting her to arrange a date. Records also show that progress (or lack of it) was discussed in supervision on a few occasions.

Summary of learning: Child and grandparent's views

Recommendations

- Relationship building would be better done more naturally as part of another activity, for example collecting children and young people from school
- Children may be more inclined to disclose concerns if they know how they are likely to be handled and what the likely outcome will be (e.g placement ending)
- Thought should be given as to how to encourage "hypothetical conversations" so children can test the water of potential responses
- Recognise that children may take time (several conversations) to disclose if they are being abused

See Recommendation A

6. POSITIVE PRACTICE

When undertaking a review, it is important to also consider the kind of positive practice that might have broader applicability to protecting or supporting other children and families. A number of examples have been already included in the report. Examples not previously referred to are listed below

Protective and supportive actions by practitioners
After Father made a private law application the local authority sought to become party to the proceedings and produced a report about the children's circumstances which ultimately resulted in a care order
The schools provided the children with good support
Agencies made a timely response to the sexual assault Child C experienced from a peer
Agencies made a timely response to the sexual abuse allegations which prompted tis review
The LADO sent letters to the children during the investigations into the allegations that prompted this review
The LADO sought reassurance during the LADO process that the children and carers were being adequately supported by workers. The LADO provided written feedback to the children

through their social worker and to the carers through the family placements team at the end of the process.
The LADO took a wider perspective on the safety of other children with whom the foster carers had contact
The fostering agency arranged separate support for the foster carers after the allegation of sexual abuse
CAMHs conducted a review appointment before ceasing involvement with Child C
The supervising social worker's recording was of a quality that the FIRO was able to recognise the concerns over time
The IRO contacted the children's social worker to raise concerns noted in the case record or reported to him
The supervising social worker (fostering) attended all the children's statutory reviews
All statutory reviews were held in the foster home which is good practice to observe carers and children in the home
To address delays regarding the children who had had contact with the male carer being spoken to the LADO escalated his request to a service manager

7. CONCLUSION

7.1. National analyses of Serious Case Reviews[40] (which were the precursor to Child Safeguarding Practice Reviews) consistently show that children who are the subject of these often look very similar to those other children who practitioners encounter in their day-to-day work. This highlights a key challenge in identifying those individual children that are at risk of serious harm or death.

7.2. However, had all the incidents, concerns and allegations been known about and viewed collectively earlier then a more concerning picture might have emerged sooner. The mapping meeting in April 2020 began that collective process but could not include incidents which were not known to the practitioners present. It is acknowledged that some of these were not a significant concern without the benefit of hindsight, although bringing them together might have prompted a discussion about the threshold and what to do if concerning comments or behaviours persisted. Several practitioners felt uncomfortable, but it is hard to translate that into decisive action where there is no tangible evidence of abuse or other serious impediment to their suitability as foster carers.

8. RECOMMENDATIONS

The individual agency reports have made single agency recommendations. Leicester Safeguarding Children Partnership Board (LSCPB) has accepted these and will monitor their implementation. To address the multi-agency learning, this Child Safeguarding Practice Review identified the following recommendations for LSCP.

[40] Chapter 6 Brandon M et al (2010) Building on learning from Serious Case Reviews; two year analysis from child protection notifications database 2007-9 DfE Sidebottam P et al (2016) Pathways to harm pathways to protection; a triennial analysis of Serious Case Reviews 2011-14 Department for Education

A. That LSCP involves looked after children in a wide-ranging "help me tell you anything" initiative to support children recognising and expressing concerns to practitioners. This should include children of all ages and abilities.

B. That LSCP updates its Sexual Abuse procedure to "think the unthinkable" and remind staff that abusers can include foster carers (and adoptive carers and special guardians) and make use of the assessment template developed by the Centre of Expertise on CSA

C. That LSCP seeks reassurance from fostering services that:

   I. arrangements are in place so that essential activities to minimise risk of abuse are monitored and any deficits addressed. This should include key components being monitored via the monthly quality assurance data and audits of case records with action plans being in place for any deficits in practice.

   II. any professionals' meetings convened to discuss emerging concerns are multi-agency

   III. That fostering staff are aware of the learning from this case about reassessment and that this has been incorporated into the local practice standards and electronic procedures

D. That LSCP seeks assurance from each agency involved in this review that learning points have been identified and action has been/or is being taken to address and disseminate them.

E. That the LSCP agrees what arrangements will monitor the impact of action arising from addressing recommendations A and B