

city & hackney
safeguarding
children board

Serious Case Review

Overview Report

The sexual abuse of children in a foster home

November 2014

Author: Keith Ibbetson

Introduction

Between September 2013 and November 2014, the City and Hackney Safeguarding Children Board conducted a Serious Case Review about the sexual abuse of a number of children by two men. One was an approved foster carer, the other a member of his family. The abuse of foster children is known to have taken place between 1999 and 2008. This report presents the full findings of the review.

The function of the Serious Case Review has been to provide a rigorous analysis of the actions and decisions of professionals in order to explain how the man concerned and his wife were approved as foster carers, whether concerns were identified when the abuse was happening and why it was not recognised. These are questions that the young people who were victims of abuse told the review were of great importance to them. The Serious Case Review has also identified ways in which professionals who work with vulnerable children, and the agencies that employ them, can make it more difficult for those who seek to abuse children to gain positions of trust and make the care of looked after children safer.

The Serious Case Review has been unusually challenging because it considered the provision made to a number of children, over a period of almost two decades. Many of the children involved now live far from Hackney. The history that needed to be explored was potentially unsettling for both professional and family participants, especially as the review was being conducted shortly after a criminal trial at which a number of young people had given evidence. The Board is grateful for the cooperation of everyone who has supported the work of this review over the last year, particularly the young people and their families and carers.

It is recognised that many of the events considered by the Serious Case Review took place over a decade ago. Many of the services that are described in this report have altered substantially in the intervening years, some it can be argued beyond recognition. There have been many changes in the regulations and guidance that govern the quality of care that is provided for looked after children. Despite these changes, the findings of the Serious Case Review will be of considerable current relevance to agencies that are responsible for children who are looked after away from their homes, particularly in the way that it brings together vital lessons about the behaviour of those who seek to take advantage of positions of trust and responsibility to abuse children.

In order to make the learning from the Serious Case Review as accessible as possible the findings of the overview report are arranged in the following way.

- Part 1 of the report is an Executive Summary which provides an overview of the key events and findings
- Part 2 explains why the review was initiated and how it was undertaken
- Part 3 provides a narrative of key events. The level of detail is limited in order to protect the privacy of the young people
- Part 4 of the report evaluates in detail the episodes when there were opportunities to detect the risk of abuse. It also sets out some wider lessons in relation to the sexual abuse of children and the protection of children who are in public care.
- Part 5 contains the recommendations made for individual agencies and the City and Hackney Safeguarding Children Board.
- Part 6 of the report sets out a detailed account of the recruitment of the foster carers and the way in which professionals related to them. This very detailed information has been included because it is right to offer a full account of this to the victims. It will be of particular interest to those who work in and manage fostering services.

Alongside this report the City and Hackney Safeguarding Board has published a formal response to the findings of the Serious Case Review and an action plan setting out in detail the actions that agencies and the board will now take to implement the learning from the review.

The sexual abuse of children in a foster home

	Contents	page
1	Executive Summary	3-8
2	The work of the Serious Case Review	9-12
3	Key Events	13-17
4	Evaluation of Professional Practice	18
	Wider lessons for safeguarding services about the nature of child sexual abuse, the experiences of children who have been abused and the way in which perpetrators operate	31-36
5	Recommendations	37-39
6	Historical evaluation of safeguarding arrangements for looked after children in Hackney	
7	Appendices	66

1. Executive Summary

The sexual abuse

- 1.1. A married couple were approved foster carers for Hackney Council between 1997 and 2011. The foster carers lived in another local authority area. During this time they fostered over thirty children, most of them for short periods, or for a series of respite care stays. Eight looked after children lived in the household for more than a year.
- 1.2. Between 1999 and 2008, five girls of primary school age, who were all in the care of Hackney Council, were sexually abused in the foster home. This came to light in late 2012 after one of the victims made allegations to the police. In 2013, the male foster carer was convicted of more than twenty sexual offences against five looked after children which include rape, sexual assaults and acts of indecency. He was also convicted of offences against another child who lived in the local community and admitted sexual offences committed against an unidentified young person, committed some thirty years previously. A second male member of the foster family was also convicted of sexual offences against one looked after child.
- 1.3. The male foster carer made videos and photographs of some of the assaults. When he was arrested he was found to possess a very large number of downloaded child abuse images. According to another family member, many other images, including photographs that he had taken, had been destroyed or had disappeared. The police have found no evidence that the male foster carer had contact with other paedophiles or that he distributed the images of abuse that he created. However, he was adept at the use of information technology and had the means to do this.
- 1.4. After the disclosure of abuse, two family members stated that the female foster carer knew that children were at risk of sexual abuse. She is now known to have been involved in sexual activity (not involving children) with other adults which took place in the family home. While not in itself illegal, had it been discovered this activity would have led to her deregistration as a foster carer. Both foster carers therefore had a strong motivation to keep what was happening in the household secret.
- 1.5. No evidence has been found that any professional person was aware of the sexual abuse at the time when it was taking place. The young people did not confide in anyone for many years. When they did, some spoke to people in their private lives whom they had known and trusted, rather than to professionals. One victim mentioned her experience to a counsellor some years after she had left the foster home. Other victims did not speak to anyone until they were approached by the police during the course of their recent investigation.

Anonymous allegation of possession of child abuse images made in 1999

- 1.6. There was an early opportunity to prevent the abuse of some of the children. In 1999 the Metropolitan Police Service (MPS) received an anonymous allegation that the male foster carer had shown what was reported as "child pornography" on his computer to children in the neighbourhood. The caller stated explicitly that the alleged perpetrator was a foster parent. According to the accounts now given by victims, this incident pre-dated by some months the first episode of sexual abuse in the foster home.
- 1.7. The MPS failed to investigate this allegation but kept the information as intelligence for possible future use. The MPS provided no information about the allegation to the local authority in the area where the foster carer lived so no enquiries could be made by children's social care staff. Hackney's social care service (which was responsible for the foster carers and all of the looked after children in the household) was also not informed.

- 1.8. It is not possible to say whether a police investigation would have led to criminal charges. However, if the MPS had shared information about this allegation with the relevant local authorities it would almost certainly have led to the immediate removal of fostered children and the de-registration of the foster carers.
- 1.9. The MPS recognises that its failure to investigate this information was a very serious breach of its responsibility to protect the public. It has been unable to explain why this happened as the original paper records of the incident have been summarised onto an electronic record which does not indicate which officers were involved or how decisions were reached.
- 1.10. The Serious Case Review has recommended that the MPS takes whatever further steps are available to it to ensure that all possible avenues of enquiry have been exhausted to fully understand why the allegation was not investigated.
- 1.11. In the MPS management review, it states that police understanding of the significance of possession of child abuse images and MPS systems for tracking the response to referrals have advanced significantly since 1999 and that it is highly unlikely that same individual or organisational failure could reoccur.
- 1.12. Whilst acknowledging this position, in the absence of a full understanding of why the allegation was not investigated, the Serious Case Review has asked the MPS to review and provide further reassurance that its current arrangements for dealing with such allegations are robust and in line with the London Child Protection Procedures.

Non-disclosure of 'soft intelligence' by the police

- 1.13. Information about the 1999 allegation was retained by the MPS and was reviewed on four occasions between 2001 and 2010 when the MPS Character Enquiry Centre (CEC) responded to requests for updated police checks on the foster carers' household under the Criminal Records Bureau (CRB) and later Disclosure and Barring Service (DBS) arrangements.
- 1.14. Each time the allegation surfaced because of the request for a police check there were grounds for the MPS to have revisited the original failure to investigate the claim – especially as the renewed request for a check confirmed that the individual was still a foster carer. While the CEC had no investigative role, it should on each occasion have brought the information to the attention of colleagues in the local MPS Child Abuse Investigation Team.
- 1.15. The CEC recognised that the allegation constituted 'soft intelligence' (the term used to describe a range of information that may be held usually in local police records and in the records of specialist child abuse investigation teams) which it should consider disclosing, but on each occasion it decided not to do so. As a result the information was never shared with Hackney Council. Had this happened, Hackney Council would have investigated further in order to determine whether the couple should continue to act as foster carers.
- 1.16. In determining whether to disclose information about the allegation as part of the CRB / DBS checks the MPS referred correctly to its duties under the Police Act 1997, subsequent Association of Chief Police Officers (ACPO) and Home Office guidance and to the leading legal case. In deciding not to do so it gave too much weight to the fact that the original allegation was uncorroborated, bearing in mind that this was entirely due to its own failure to investigate it properly in 1999. It also gave too little weight to the likelihood that a man who may have been in possession of child abuse images would be likely to continue to accumulate similar material and that this might be part of a pattern of offences against children or a precursor to such offences.

- 1.17. The Serious Case Review accepts that all of those involved in these decisions acted in good faith and in accord with the approach to decision making laid out by senior officers in the MPS. However the MPS placed too much weight on the wording of particular sections of the guidance and gave insufficient consideration to the specific circumstances of the case, the overall intention of legislation and guidance, the vulnerability of children living in foster care and the duty of the police to protect the public.
- 1.18. It is likely that in any similar case the MPS will have taken the same approach so there is no guarantee that other children have not been placed at similar risk. The Serious Case Review has therefore recommended that the MPS should audit its decision-making in other cases where soft intelligence about those seeking employment with children has been withheld from prospective employers during DBS checks. It should also review its current policy and practice.
- 1.19. It falls outside the remit of the Serious Case Review to consider whether the approach adopted by the MPS has also have been followed by other police services, but this possibility should be investigated. ACPO should consider the wider implications for police services. Depending on the outcome of wider enquiries about the practice of other police services there may also be grounds for review of the current Home Office guidance.

The ability of professionals to understand and respond to sexual behaviour which is outside developmental norms

- 1.20. None of the children made allegations of abuse during the period when there were looked after children living with the foster carers. However there were a number of reported concerns about the very sexualised behaviour of one child, both during the period when she lived with the foster carers and in her subsequent placement. This was not investigated by the local authority which too readily accepted explanations provided by the female foster carer that the behaviour had been learnt and copied from the child's birth mother, when there was no evidence to support that assertion.
- 1.21. Later on, concern about this specific pattern of behaviour was lost as professional attention focused on a range of wider behavioural and developmental concerns. The local authority has recognised that professionals need to have a much better understanding of norms in relation to the development of sexual behaviour so that concerning patterns of behaviour can be recognised, monitored and investigated if necessary.

Seeing, hearing and helping looked after children

- 1.22. The difficulty that professionals had in recognising the risk from the foster carers may have arisen from an underlying assumption that children who are looked after are not at risk from their carers. Whilst the evidence is that the overwhelming majority of foster carers offer safe care, it is important for professionals to recognise the small risk that abuse may occur in any form of substitute care. There is in addition a wider risk that looked after children are more vulnerable to other forms of victimisation, such as bullying. It is therefore important that for every looked after child there is an awareness of the potential for further victimisation and that care plans detail the action required from all professionals to safeguard the child from further abuse and harm. These actions must be implemented, closely monitored and updated.
- 1.23. When a child is believed to have suffered sexual abuse before becoming looked after, the local authority care plan should include provision for educational and protective work to reduce the likelihood of further abuse. If there are signs or symptoms of possible sexual abuse then professionals need to be open minded as to who may have been responsible

and not dismiss the possibility that a person who has a professional role in the child's life has harmed the child.

- 1.24. For most of the children who are the subject of this review there was insufficient direct contact between the children and the social workers who were allocated by the local authority to work with them. Many of the children experienced large numbers of changes in their allocated social workers, especially in the period before 2007. A number of the children reported that some of their social workers had been unreliable, for example by being repeatedly late, not keeping appointments or changing them at short notice.
- 1.25. It is important that social workers and other professionals should see children regularly, be reliable and keep appointments. However it would be wrong to draw the conclusion that simply visiting children in line with the statutory requirements (or even more often if that were possible) would enable children to talk more freely to social workers about experiences such as sexual abuse. Children who have been abused most often chose to confide in adults with whom they have been able to build a close and trusting relationship over a period of time. Given the current range of roles and responsibilities of social workers employed by local authorities the development of such relationships is very difficult to achieve.
- 1.26. Looked after children may not be able to talk to social workers about all of the most difficult issues in their lives. However it is absolutely essential that the child should see the social worker as someone who is reliable, has a good knowledge of his or her past, knows the important people in the child's life, observes the child carefully, asks thoughtful questions, listens to their views and explains things clearly. If a child has something very distressing to tell, they may well not choose to disclose it to the social worker, but they need to have a strong sense that the social worker is part of a group of people around the child who can understand and deal effectively with troubling information. That would significantly increase the likelihood of the child choosing to tell someone.

Concerns about the quality of care provided by the foster carers

- 1.27. There is no evidence that children made allegations of sexual abuse by the foster carers until some time after they had left their care. However between 2003 and 2006 a number of social workers recognised and recorded concerns about the standard of physical and emotional care that was being provided for some children by the foster carers. For example, their bedroom was too small, the house as a whole was overcrowded and one social worker felt that the children were being neglected. Two members of Hackney social care staff reported concerns that the female foster carer was unprofessional and uncooperative.
- 1.28. The concerns voiced by these members of staff were not addressed properly by Hackney's fostering service because over time, it had developed an uncritical and unhealthy relationship with the foster carers. This began in the late 1990s when the foster carers were recruited because they had been perceived as being flexible, child centred and happy to assist the local authority. In contrast many of Hackney's more established foster carers were perceived as being rigid in their approach and not responsive to the needs of individual children.
- 1.29. The social worker who assessed the foster carers prior to their approval subsequently became their first supervising social worker and then a team manager in the fostering service. Doubts about the carers' motivation for fostering identified at the fostering panel were not kept under review because initial placements with the carers were seen as being successful. There illustrates the risk (still potentially present in any fostering service) that individual workers and the service as a whole may develop an uncritical pride in and

loyalty to 'their' foster carer. Services may be unwilling to challenge or criticise carers because they work with some extremely difficult young people and are a valued resource. There is a danger that this may lead the team or service to downplay or 'not hear' critical comments about the standard of care provided. In this case, it meant that negative information about the carers was minimised and not acted on.

'Grooming' or 'conditioning' of the professional network by the foster carers

- 1.30. The development of this attitude was encouraged by the deliberate actions of the foster carers who sought to cultivate a favourable impression among professionals and to deflect or dampen any criticism. The conditioning of the professional network was a complex process in which the foster carers behaved differently towards different professionals.
- 1.31. At times the foster carers sought to present themselves as having considerable expertise. They downplayed the needs of the children, providing false reassurance that they were being fully met and did not need to be referred for additional help. This limited the number of professionals involved with the children. At other times the foster carers were openly hostile to some professionals and difficult to work with, particularly for those who made any critical comment on their work. The female foster carer openly and repeatedly criticised a supervising social worker who had expressed concerns, which served to undermine her in the eyes of her colleagues. For substantial periods the foster carers operated outside of the normal rules and procedures of the fostering service by, for example, refusing to attend training or supervision sessions. Because of their good reputation this was not properly challenged.
- 1.32. An awareness of patterns of manipulative behaviour should inform the recruitment, approval and continuing monitoring and supervision of all those working with children, especially foster carers who have the day to day care of some of society's most vulnerable children, of necessity with little direct supervision of their work.
- 1.33. In line with fostering regulations and guidance the foster carers were subject to annual reviews of their performance, but these were not sufficiently challenging and did not take account of potentially important information such as the experience and feedback of carers who subsequently looked after children when they had left the foster home. Some of these carers had strong reservations and concerns about the quality of care that the foster carers provided.
- 1.34. Measures put in place to test and improve the quality of foster carers needed to capture information about the care being provided from as many sources as possible, drawing on the views of looked after children, social workers and other professionals who had worked with the foster carers. In a fostering service which has a large number of carers it may be difficult to ensure that activities such as the annual review and training of foster carers remain creative and do not become routine activities.

The role of the local authority's partner agencies

- 1.35. Health and education services played a limited role in the lives of most of these children in part because the foster carers led the local authority to believe that their needs were being met in their placements and minimised concerns about their behaviour and contact with other professionals.
- 1.36. There were gaps in the provision made by the health service for looked after children. In the early years the children had few looked after health assessments and arrangements for coordinating provision for the health of children living at a distance from Hackney were weak.

- 1.37. It is recognised that there have been significant changes in the provision made for this group of children in Hackney in the decade since the service had contact with these children. During the period in which the Serious Case Review was being undertaken the local authority and health commissioners have re-commissioned the looked after health children's service from another health provider. Performance in all areas needs to be the subject of regular audit and review so that there is evidence of a genuine integration of the looked after children's health service and social work services.

Scrutiny of safeguarding arrangements in relation to looked after children

- 1.38. The children who were victims of abuse were made more vulnerable as a result of historical shortcomings in some of Hackney's children's services. Most of the children whose experience has been at the centre of this review had too many changes in social workers and experienced periods when they were not visited frequently enough or seen on their own.
- 1.39. While many of these difficulties have been addressed by changes in Hackney's social care provision that have been put in place over the last 8 years, further work is required to improve the safety of looked after children. It is very likely that these will also be relevant for many local authority and independent fostering services.
- 1.40. The local authority has identified steps that need to be taken in the following areas:
- care plans for all looked after children address their need for protection from further harm, whatever the source.
 - measures to address the individual therapeutic needs of children in care who have a history of sexual abuse.
 - professional understanding of the motivations and behaviours of people who seek to sexually abuse children and its application to the assessment and oversight of those charged with the care of looked after children.
 - management arrangements which minimise the potential for dangerous professional dynamics to undermine the effectiveness of services to safeguard children.
 - steps to ensure that the local authority fostering panel complies with statutory requirements and functions in a rigorous and challenging way.
 - annual reviews of foster carers that make use of all relevant information about carers and are challenging.
 - regular audits of fostering cases, followed by action to address concerns identified.

External scrutiny of the safeguarding of looked after children

- 1.41. Since its inception the City and Hackney Safeguarding Children Board had undertaken work to improve the response of agencies to allegations against professionals working with children, children who go missing and child sexual exploitation (all of which are important aspects of the vulnerability of looked after children). Beyond that it has played a limited role in scrutinising the safeguarding arrangements for this group of children. In this respect it is likely that the City and Hackney Safeguarding Children Board has not been very different from other local safeguarding children boards.
- 1.42. The City and Hackney Safeguarding Children Board now recognises that the safeguarding of looked after children should be a higher priority in its coordination and challenge of the work of local agencies. In particular it will develop activity and reporting to monitor the implementation by the local authority and other agencies of their work to implement the recommendations made by the Serious Case Review.

2. The work of the Serious Case Review

- 2.1. Between September 2013 and November 2014 the City and Hackney Safeguarding Children Board carried out a Serious Case Review because of the sexual abuse of children living in a foster home. This overview report sets out in full the findings of the review.

Reasons for conducting the Serious Case Review

- 2.2. On 8 July 2013 the Executive Committee of the City and Hackney Safeguarding Children Board considered details of the serious sexual abuse of a number of children who had been in care to Hackney Council and living in a foster home. The abuse of these children had occurred between 1999 and 2008. Another child living in the local community had been abused some years before by the same man. The Independent Chair of the board decided to undertake a Serious Case Review.
- 2.3. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires LSCBs to conduct a Serious Case Review when a child has been seriously harmed as a result of abuse or neglect *'and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child'*.¹
- 2.4. It was not initially apparent that there had been serious failings in the work undertaken by agencies to protect the children as there was no indication of concerns about sexual abuse in the local authority records and (on initial scrutiny of the records) no evidence that indicators of possible sexual abuse had been missed. However, detailed testing of police knowledge of the family confirmed that in March 1999, the Metropolitan Police Service (MPS) had received an anonymous allegation that a person, who was easily identifiable as the male foster carer, had shown child abuse images to children in his neighbourhood. There was no evidence that these allegations had been investigated by the MPS or brought to the attention of either Hackney Council or the local authority where the foster carer lived. The Independent Chair found that in these circumstances the criteria for a Serious Case review were met.

Scope, terms of reference and details of the agencies involved in the Serious Case Review

- 2.5. The City and Hackney Safeguarding Children Board agreed the provisional terms of reference for the review in August 2013 and work began in September 2013. The final terms of reference for the review are set out in Appendix I. The board appointed a lead reviewer and established a review team which was charged with undertaking the review. To offer an additional level of scrutiny and challenge an independent panel was established with members drawn from senior professionals from agencies that had not been involved with the children. Full details of these arrangements are set out in Appendix II.
- 2.6. The Serious Case Review evaluated the services provided by agencies between December 1995 (when the foster carers first enquired to Hackney Council about becoming foster carers) and late 2012 (when the first current allegation of abuse was made to the police). It was recognised that reviewing services provided over this period would be a substantial task but it was clear that limiting the scope of the review more tightly risked missing potentially important information. The time period covered meant that the review had a focus that was in part historical. However it was important from the perspective of the young people who had been victimised to understand the circumstances in which abuse

¹ LSCB Regulation 5 (Section 5 (2) b (ii) at page 68 in *Working Together to Safeguard Children 2013* (op cit)

had taken place and the reasons that professionals had not been able to recognise what was happening at the time. It was also clear that there would be relevant lessons for agencies that now provide services for looked after children, particularly fostering services.

- 2.7. Hackney Council established that between 1997 and 2011, thirty-five children had been placed in the foster home, for periods of between one day and three and a half years. Some additional placements, all of very short duration, were also made by the borough's emergency duty team which had not been identified in local authority records. The majority of the placements made by the local authority were for short term or respite periods. Fourteen children had lived in the household for more than three months, including eight children who had lived there for more than a year.
- 2.8. During their joint investigation which preceded the Serious Case Review, the Metropolitan Police Service and Hackney Council identified children (in addition to those who had made allegations) who were most likely to have been at risk of abuse. A number of young people and their carers were contacted so that they could express any concerns about the way in which they had been treated in the foster home. Having reviewed material gathered in the criminal investigation it was agreed that the Serious Case Review would concentrate its attention on the contact that agencies had had with eight young people who were known to have been abused or appeared to have been significantly affected by the abuse. More than twenty agencies in localities covered by five local safeguarding children boards had provided services for these children.
- 2.9. All of the identified victims of abuse had been girls of primary school age. Later in the review, the records of four other children were also scrutinised in order to establish if there appeared to be any significant additional information or lessons arising from their contact with the foster carers or other agencies. Recognising that other children may also have been abused or adversely affected by their contact with the foster carers none of these children fell within the perpetrator's apparent target group. This exercise did not lead to further concerns about abuse or any significant additional learning.

Method of undertaking the Serious Case Review

- 2.10. All of the agencies known to have been involved with the children were asked to review their records, prepare a chronology and identify any material which was potentially relevant to the SCR terms of reference. Depending on the legal status and age of the young person concerned, consent was sought from the young person or another appropriate person.
- 2.11. Based on the initial chronologies, three agencies whose involvement in the children's lives was the most significant were required to submit comprehensive individual management reviews. These were:
- Hackney Council (which approved and supervised the foster carer) and was responsible for all of the children who were placed in their household
 - Metropolitan Police Service
 - Health Service Provider for looked after children

The reviews were prepared by experienced managers and advisors with safeguarding expertise and discussed at review team meetings.

- 2.12. Other agencies involved included schools, health and mental health services attended by the children both during and after their time with the foster carers. The review team

- obtained copies of specific records and documents from these agencies in order to review important episodes.
- 2.13. Details of the other agencies involved have been deliberately omitted from this report because naming them would indicate where the young people involved live or had lived. This would have substantially increased the risk of identifying the children and might lead to a breach of their right to a private and family life. It might also be in breach of orders made to protect the children at the criminal trial. It was agreed that this risk substantially outweighed any additional benefit that would arise from identifying the agencies publicly.
- 2.14. All of the agencies concerned and the local safeguarding boards on which they are represented have been fully involved in the review and have been made aware of its findings in order that they can take any action that they believe to be necessary. The chair of the local safeguarding board in the area where the foster carers lived has been closely involved in the planning and conduct of the SCR and was a member of the independent panel.

Involvement of key professionals, young people and family members

- 2.15. The Serious Case Review has been carried out in accordance with the statutory guidance and principles set out in *Working Together to Safeguard Children 2013*. These are set out in Appendix I.
- 2.16. During the preparation of the individual management reviews, the authors identified and interviewed key members of current and former staff. To avoid the need for repeat interviews, the Serious Case Review team and Hackney Council conducted joint interviews with sixteen current and former staff who had been involved with the children, the foster family or relevant services. The lead reviewer also held interviews with current and former senior managers and advisors.
- 2.17. Members of the review team met with young people who had been victims of abuse. Their contributions have been important and are reflected at a number of points in this report. A number of other young people were identified as having been affected by the review and contact was made with their current families and carers. Members of the review team decided that, taking into account their welfare and a variety of reasons such as age and the impact of the recent criminal trial, it was better not to seek to involve them directly in the review. One young person made a conscious decision not to participate. Adults who had cared for a number of other children after they left the foster home were interviewed. Their contributions are also reflected at a number of points in this report.
- 2.18. During the review, young people and carers raised wider concerns about the quality of provision made during the time that the young people were in care. These have been reported to the agencies concerned and are only mentioned specifically in this report when they are considered relevant to the vulnerability of children to abuse.
- 2.19. The male foster carer agreed to be interviewed by members of the review team. This offered some insights into his behaviour and information which is included in the report. The female foster carer did not respond to the offer to participate in the review.

Impact of the parallel criminal proceedings

- 2.20. The MPS conducted the criminal investigation into the allegations of sexual abuse which led to the conviction of the two members of the foster carers' household. The police officers who led the investigation have offered considerable support to the Serious Case Review by providing information about the whereabouts of victims and witnesses and encouraging a number to participate. Interviews with witnesses and victims to support the review were delayed until the conclusion of the criminal proceedings.

Timescale for completion of the Serious Case Review

2.21. The original timescale set for completion of the Serious Case Review (March 2014) was not met due to a number of factors:

- Delay in some aspects of the review which could not start until after the criminal proceedings
- Difficulties caused by approach taken to the scanning of historical documents by Hackney Council which made it difficult to review the case records of some young people
- The significant number of staff members and former members of staff to be interviewed
- The need to have discussions with a number of young people, family members and those who cared for the children after they left the foster home and consideration that needed to be given to the timing of this.
- The fact that young people and adults were living in a number of different local authority areas some distance from Hackney.

The CHSCB Independent Chair was regularly briefed about the progress of the review and has regularly tested the reasons for delays both within the CHSCB and participating agencies. The CHSCB provided regular updates to the Department for Education over the progress of the review.

A review that is fair as well as thorough

2.22. As well as being thorough in its scrutiny and evaluation of events, the Serious Case Review has sought to be fair. It has judged the actions of professionals and agencies against established standards of good practice as they applied when the events in question took place. When the actions of individuals, groups of professionals or agencies as a whole, are found to fall short of established professional standards this is stated, together (where possible) with an explanation of why that happened.

2.23. Attention is sometimes focused on the actions of individuals, because the actions of individuals made (or could have made) a difference. The review has also tried to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken. The focus on the team, the service, the agency as a whole and the collective actions of agencies does not diminish the responsibility of individuals to act professionally and to work effectively. It explains the factors that sometimes make it harder for them to do so.

2.24. There is self-evidently an advantage in being able to review the history of professional involvement with a group of children with an overview of events and knowledge of outcomes. However, along with the clarity that hindsight offers, the SCR has taken account of the danger of what is termed 'hindsight bias'. There is, for example, a danger of reviewing what may now obviously appear to be signs and symptoms of abuse and automatically assuming that they could have been recognised and should have been acted on at the time.

3. Key Events

3.1. The narrative of key events provides sufficient information to enable the evaluation of services and the findings of the Serious Case Review to be understood. In order to minimise the risk of identifying the young people and other vulnerable family members it contains no detailed chronology or description of the children.

3.2. Key events identified are set out as follows:

- The fostering application and assessments
- Initial work as foster carers
- The sexual abuse of the foster children
- The allegation that the foster carer possessed child abuse images in 1999
- Concerns about poor care of foster children
- Concerns about sexualised behaviour
- The role of the foster carers after 2005
- The disclosures of abuse
- Reported family background and conduct of the carers known only once the police investigation began

The application to foster and assessment by the local authority

3.3. The foster carers approached Hackney Council in late 1995. It was recorded that they were very keen to foster. Their application took just over a year to process and Hackney Council's Fostering Panel approved them in early 1997, initially to foster one child of either sex up to the age of five. During the fostering assessment the male foster carer gave some information about the periods that he had spent living away from home during his childhood. He said his memories were vague though it is now clear that he withheld important details that he in fact remembered well.

3.4. The applicants stated that the female applicant was already a registered child minder and had worked with a local voluntary family support organisation, though these details were not checked. They also stated that she had had relationships with other men in the past but that their marriage was now exclusive and stable. Section 6 of the report considers in detail the fostering recruitment process, including the references and checks that were undertaken and the extent to which the assessment investigated the applicants' personal histories and reasons for wanting to foster.

3.5. During this period there was a strong push within the local authority for the fostering team to recruit because of concerns about the quality of many existing Hackney foster carers. There were also concerns about the cost of making placements in the private or independent sector and of the quality of some of those placements. The tighter fostering market meant that neighbouring authorities that had often shared foster placements were now much less willing to do so.

3.6. After their approval the social worker who had undertaken the assessment became the foster carers' supervising social worker (referred to subsequently as SSW1). This was in line with normal practice in the fostering service. In this role he was responsible for oversight of the foster carers, making regular visits to see the children in their care, liaising with social workers who placed children in the family, ensuring that they attended training programmes, dealing with any concerns that arose and coordinating the foster carers' annual reviews. These functions are all considered in detail in Section 6. SSW1 continued in this role until 2002, when he was promoted within the fostering service.

Initial work as foster carers

- 3.7. Between 1997 and late 1998 the local authority placed thirteen children with the carers. One male infant lived with the family for 18 months while the other children were all placed for brief emergency or respite care placements. For most of this period there were two foster children in the placement which was outside the terms of the original approval. The local authority's adherence to fostering regulations is discussed in Section 6 of the report.
- 3.8. During this period Hackney's fostering service came to view the foster carers very positively because of their flexibility and their apparent focus on the needs of the children who were placed with them. They would accept placements of children with a range of needs and were cooperative when children had to be placed quickly. They were perceived as having worked in a very open way with birth parents. One of the children placed had a hearing impairment and three members of the family completed courses in sign language. The foster carers took trouble to provide photos and mementos for the parents of the children who were placed with them and for 'life story work' to help children who were moving into permanent family homes.
- 3.9. Staff involved told the Serious Case Review that these were all qualities that many other Hackney carers lacked at the time. The way in which the foster carers presented themselves to professionals is considered further at a number of points in Section 4 and Section 6.

The sexual abuse of the foster children

- 3.10. Between 1998 and late 2005 the couple fostered two sibling groups of primary school age children. The male foster carer sexually abused three of the children from one family. He and another family member sexually abused one of the children from the second family. The persistent behavioural and emotional difficulties experienced by the other children in this second family leads to the strong suspicion that they were also abused or witnessed abuse. The practical living arrangements within the foster home make this very likely. This is discussed further in Section 6.
- 3.11. The abuse of the children included rape, sexual assault and acts of indecency. The male foster carer made videos and photographs of some of the assaults. When he was arrested the male foster had in his possession a very large number of downloaded child abuse images.
- 3.12. According to another family member, computer hard drives, video tapes, CDs and printed photographs containing other such images had been destroyed or had disappeared. The police have found no evidence that the male foster carer had contact with other paedophiles or that he distributed the images of abuse that he created. However he was adept at the use of information technology and had the means to do this.

Allegations that the male foster carer possessed child abuse images

- 3.13. In March 1999 the Metropolitan Police Service (MPS) received an anonymous allegation that the male foster carer had shown what was described as 'child pornography' on his computer to several local children. This was after the first sibling group had been placed but, according to the testimony of the victims, before the sexual abuse of these children began.
- 3.14. The police do not have the complete records of this episode because the original paper documents were summarised onto a computer system as part of a routine modernisation of records. However the MPS has accepted that there is no evidence that any action was

taken to investigate the allegation. Nor is there evidence in police or local authority records that the information was shared with the local authority (either in Hackney or in the area where the family lived).

- 3.15. The anonymous report made clear that the person concerned was a foster carer. It contained some slightly inaccurate information about the person's name and address though it is clear from police records that this was easily rectified and the foster carer was identified as being the person concerned. This episode is considered further in Section 4 of the report.
- 3.16. This information was available to the MPS when in 2001, 2004, 2007 and 2010 it was asked to consider whether it had relevant information that it ought to disclose to Hackney Council as part of the required review and update of Criminal Records Bureau (CRB) and later Disclosure and Barring (DBS) checks.
- 3.17. Although members of the foster family were subject to the correct enhanced checks the police decided on each occasion not to disclose the information that it held about the 1999 episode. The action taken and the framework of public policy, guidance and case law that shaped these decisions are discussed in Section 4. On each of these occasions the MPS also did not take the opportunity to investigate the original allegations.

Concerns about poor physical and emotional care for foster children

- 3.18. Between 1999 and 2006 members of Hackney Council's fostering service remained largely positive about the care provided by the foster carers, for the reasons set out above. In 2002 and then in 2003 there were changes in supervising social workers. In mid-2003 the family's fourth supervising social worker (SSW4) was appointed. She was involved with the foster carers for the rest of the period under review.
- 3.19. Between 2002 and 2008 a small number of social work staff (including an allocated social worker for one of the sibling groups and SSW4) expressed reservations about aspects of the care that was being provided, though they did not have evidence of or suspect sexual abuse. Concerns centred on the following:
- the overcrowded and chaotic nature of the foster home
 - observations that foster children were treated differently to the foster carers' own children (for example having meals of a poorer quality)
 - the presentation and demeanour of three of the foster children
 - poor take up of training by the foster carers
 - the attitude of the female foster carer to professionals, particularly SSW4
 - the female foster carer's open hostility to unannounced visits by one allocated social worker
 - her desire to work outside plans and arrangements made by the local authority (including for example when children were introduced to permanent carers)
- 3.20. The concerns were expressed largely in discussions with members of the fostering service. The actions taken within the local authority in relation to these matters are discussed in Section 4.
- 3.21. Records of placements show that for over a year (during 2002-2003) there were four children fostered in the household and for a period of several weeks in 2003 there were five. The interpretation placed on the fostering regulations by the local authority is discussed in Section 6.

Concerns about the sexualised behaviour of a foster child

- 3.22. Records and interviews show that one of the foster children who lived in the foster home between 2002 and 2005 behaved in a very sexualised way, both during her placement with the foster carers and towards the male carer in her next placement.
- 3.23. The female foster carer asserted at the time that this behaviour had developed before the child came into local authority care. There was no evidence to support this. The Serious Case Review has considered whether if this behaviour had been considered more carefully and investigated it may have presented an opportunity to identify the risk of sexual abuse. The actions taken by the local authority and other agencies in relation to these concerns are set out and discussed in Section 4.

The role of the foster carers after 2005

- 3.24. During 2006 - 2007 two infant boys were placed together in the foster home. No concerns were reported about their care.
- 3.25. In 2007, the local authority placed a girl of primary school age with the family while it sought to obtain the court orders required to place her with a suitable permanent family. The male foster carer has admitted taking indecent photographs of this child and another family member has stated that he witnessed him sexually assault her.
- 3.26. This child was placed in a permanent family in 2008. By this time the foster carers (particularly the female foster carer) had come to be seen as having considerable expertise by the local authority and they had started to take on roles which went beyond those of normal foster carers, despite the concerns listed above about the quality of care that had been provided for some of the children in their care. For example, the female foster carer was closely involved in the selection of the child's long term carers, first by eliminating a number of prospective families from the written applications and descriptions and then by visiting the two shortlisted families with the allocated social worker.
- 3.27. After this child's placement in 2008 her carers were sent photographs of her, some of which they found concerning. Although the photographs had been carefully cropped and edited, it seemed likely to them that the child had been naked when she was photographed. In a large number of the photographs the child is posed in a precocious manner, too often for the photographs to have been taken in the normal course of family life or by chance.
- 3.28. The new carers thought hard about what to do but did not report their concerns to the local authority. Apparently similar photographs of other children had been sent at an earlier point to the permanent carers of other children, though at the time they did not identify them as being concerning.
- 3.29. In 2007 the female foster carer took up paid employment in a care home for adults, saying at the time that she was employed during the day. Only one further child was placed with the foster carers. She was an adolescent who consistently said that she felt very happy and settled in the placement and has stated that she was not abused.
- 3.30. From mid-2008 the female foster carer withdrew almost totally from contact with the local authority (although she remained a registered foster carer) leaving the male foster carer to attend meetings with social workers and review meetings. In 2009 she told the local authority that she was now working some night shifts and willingly engaged with SSW4 in a discussion about 'safe care' arrangements in the family (for example that family members would not enter the foster child's room and that they would wear modest clothing around the house).

The disclosures of abuse

- 3.31. The first report of sexual abuse was made by one of the victims to a friend in 2009 and to a counsellor by another of the victims in 2010. The counsellor did not share this information with an agency with a statutory responsibility to investigate it. This episode is discussed further in Section 4. Local authority contact with the foster family ceased at the end of 2011 when the last foster child placed with the family left local authority care. The local authority and the police had no knowledge of the allegations until late 2012, when victims first approached the police.

Reported family background and conduct of the foster carers

- 3.32. The male foster carer had a troubled childhood during which he suffered neglect and abuse in his family home. He spent substantial periods (during the late 1960s and the 1970s) living with relatives and in care. He told the Serious Case Review that during this time he was sexually abused by a professional working in a residential education setting. According to information obtained by the police from two family members, the female foster carer was also sexually abused as a child. Reports that the foster carers had themselves been victims of abuse became known to professionals only after the allegations of sexual abuse were made in 2012.
- 3.33. After his time in institutional and foster care, the male foster carer moved into the family home of the female foster carer which was in the locality where he had grown up. The foster carers began their relationship during this period.
- 3.34. During this time, the male foster carer sexually abused a neighbour's child. He told the Serious Case Review that early in their relationship the couple spoke openly about the fact that they had both been sexually abused. Neither felt that the experience had caused them harm. He told the Serious Case Review that at the point when they applied to foster, his wife was aware that he had a sexual interest in children. He reported that this remained a topic of discussion between them. This information was also not known until after the allegations of sexual abuse were made in 2012.
- 3.35. Throughout the foster carers' relationship, including the period when she was a foster carer, the female foster carer had sexual relationships with other adults, met either socially or via the internet. She had sex with a number of men in the family home and made explicit videos for the male foster carer. He is known to have shown them to at least one foster child. No professional had knowledge of this until the videos were discovered during the police investigation of the recent allegations.
- 3.36. The male foster carer also sexually assaulted the primary school aged child of neighbours over a period of approximately three years in the 1990s before the couple made their application to Hackney Council to foster.

4. Evaluation of Professional Practice

4.1. The evaluation of the key events and professional practice in this case has identified a number of episodes when different actions might have resulted in the earlier recognition of the risk of abuse. Three of these occurred while the abuse was still taking place and might have led to the protection of some or all of the children.

4.2. The evaluation has also brought together learning about the nature of child sexual abuse, the experiences of children who have been sexually abused and the way in which perpetrators operate. This highlights the challenges for professionals and the wider public in identifying and tackling child sexual abuse. These are not new. Describing them does not diminish the responsibility of professionals to combat this abuse, but sets a context to understand why this can be so difficult. This part of the evaluation begins at Section 4.90.

Specific opportunities for the earlier identification of abuse

4.3. The Serious Case Review has identified three specific episodes when different action or decisions might have led to the earlier detection of sexual abuse and the protection of the children. These episodes are:

- The police response to the alleged possession of child abuse image
- The police response to the request for disclosure of information for checks on the foster carers (the same decision was taken on a number of occasions)
- The response to evidence of sexualised behaviour

4.4. There were also two episodes that occurred after the abuse is believed to have ended:

- Photographs given to a family who subsequently cared for the children
- The response to an allegation of abuse made in a counselling session

Police response to the alleged possession of child abuse images in 1999

4.5. In March 1999 the Metropolitan Police Service (MPS) received an anonymous phone call alleging that the male foster carer had been 'openly showing' what was described as 'child pornography' held on CD discs to children in the neighbourhood. This allegation was made two years after the approval of the foster carers, but shortly before the victims say that the sexual abuse of the first foster children began.

4.6. The informant provided an incorrect surname for the foster carer and made a slight error in the address; but he or she clearly knew the foster carers well enough to correctly identify the composition of the family and the number of foster children living in the household. Metropolitan Police Service (MPS) records show that the police readily identified the correct details and address from the electoral register. The fact that the alleged suspect was a foster carer was clear from the allegation and could have been quickly confirmed through records of the Criminal Record Bureau (CRB) checks that had already been undertaken at the time of Hackney Council's fostering assessment in 1996.

4.7. It is not possible to tell which section of the MPS received the original call. The surviving MPS record of this episode is an electronic summary of the original paper docket. The MPS has told the Serious Case Review that this document no longer exists because the records were transferred to a new system at some time after 2000. None of the reference numbers on the electronic record refer to existing information systems or have enabled additional records to be traced.

4.8. There is only one very limited record of the action taken in response to the allegation. In October 1999 (six months after the phone call) a further record summary notes the

following: *'Enquiries made with local Child Protection Team (now the Child Abuse Investigation Team). Not known. Time has not allowed a full investigation and this docket (the paper record which cannot be traced and has likely been disposed of) is passed back to focus desk for further research or to be PA (put away) until evidence comes to light'*.

- 4.9. The MPS has made extensive enquiries in order to seek the original document and to trace members of staff, including a number now retired, who dealt with the enquiry or may have done so. The detail of the steps taken runs to four pages in the report prepared by the MPS for this review and the Serious Case Review has no reason to believe that the efforts made have not been diligent. None of the police officers interviewed has any specific recollection of the episode. Given the passage of time and the nature of the enquiry this is not surprising. As the allegation was not properly investigated, it is probable that the police officers and staff members involved would only have dealt with the records very briefly.
- 4.10. The MPS has been unable to explain why this happened but accepts that the failure to pursue the allegation was an extremely serious error. The records quoted above indicate that the information was treated as intelligence, which would have been checked to see if it had more significance in the light of other information already held by the MPS and then retained. According to the MPS it would have been considered by its Paedophile Unit, which at that time investigated the possession of child abuse images as well as allegations of complex or organised abuse. However, the reference to the Child Protection Team strongly suggests that one of the local teams, which held operational responsibility for the investigation of child abuse allegations, was contacted to see if the family was known.
- 4.11. There is also no evidence, either in Hackney Council or in the local authority area where the family lived, that the MPS shared the information with social care staff who would then have convened a strategy meeting to determine how to respond. Both local authorities are clear that at that time they had systems in place for dealing with allegations against professionals working with children and would have been extremely concerned about potential risks to the children if the allegation had been brought to their attention.
- 4.12. Had that happened, the allegation would have met the threshold for criminal investigation and social care enquiries under Section 47 of the Children Act 1989. Whilst it is impossible to be certain what action would have subsequently been taken, unless there had been positive proof that the allegation was false or malicious it is difficult to believe that the foster carers would not have been prevented from fostering.
- 4.13. The MPS has considered the current significance of this incident for its child protection responsibilities. In the management review that it has prepared for the Serious Case Review, it states that police understanding of the significance of possession of child abuse images and MPS systems for tracking the response to referrals have advanced significantly since 1999 and that it is therefore highly unlikely that same individual or organisational failure could reoccur. It therefore makes no recommendation for further action by the MPS.
- 4.14. Notwithstanding these developments, without knowing exactly why the MPS did not deal with the allegation properly, there remains a risk that the same shortcomings could reoccur. Whilst the incident occurred 15 years ago, the gravity of what happened and the subsequent impact on the victims make it vital that both the MPS and its partners across London are reassured that the current response of the MPS to similar allegations is

effective. The Serious Case Review has therefore made a recommendation in relation to this.

- 4.15. It has also recommended that the MPS considers whether further action can be taken, even at this late juncture, to establish why this allegation was not investigated.

Police response to the request for disclosure of information during employment checks

- 4.16. Hackney Council correctly sought checks of police records on the foster carers, members of their household and identified members of their support network during the fostering assessment in 1996 and then every three years until 2010. These were formerly termed Criminal Record Bureau (CRB) checks. Currently, information arising from such checks is shared with the Disclosure and Barring Service (DBS) which provides applicants with a DBS certificate which prospective employers ask candidates to produce.
- 4.17. Hackney Council made the checks on family members at the intervals required by the fostering regulations. On one occasion support, checks on members of the foster carers' network fell outside the three-year interval.² There is no evidence that this error was significant.
- 4.18. CRB / DBS checks on those who will have regular, unsupervised contact with children trigger a comprehensive search for information about convictions, cautions and 'soft intelligence'. This is the term used to describe a range of information that may be held (usually in local police records and in the records of specialist child abuse investigation teams).
- 4.19. Soft intelligence might include information about an unsubstantiated allegation, a 'not guilty' verdict in relation to an offence deemed relevant to work with children, dismissal from a job because of concerns about conduct towards a child or information about the fact that there had been serious concerns about the care of a child in the family which had become known to the police. Such information may in some circumstances be disclosed by the police because it is considered relevant to a person's application for a post working with children (or vulnerable adults) and the police decide that it ought to be disclosed.
- 4.20. At the time of the fostering recruitment in 1995-7, no one in the foster carers' household had a criminal record and the MPS held no additional 'soft intelligence'. In 1999, details of the allegation described in Section 4.5 were added to MPS records but the existence of this information was not subsequently disclosed when the CRB / DBS checks were undertaken. The Serious Case Review lead reviewer has discussed the reasons for this in detail with the Head of the MPS Character Enquiry Centre (CEC) which processes the checks on those living in the MPS area.
- 4.21. The view of the MPS was that at all times it acted in line with the statutory framework, Home Office guidance and case law, including a Supreme Court judgement (brief summaries of which are set out below). The Serious Case Review has concluded that whilst the MPS was diligent in seeking to comply with the law and guidance, the approach taken gave insufficient weight to its duty to protect children. In order to explain this, the Serious Case Review will comment on four matters which apply specifically to the disclosure of 'soft intelligence' in relation to those who are in regular contact with vulnerable children or adults and work in an unsupervised setting:

² Checks on named individuals in an identified support network are made so that children can have overnight stays away from the foster home or be looked after by other carers in an emergency without the need for specific checks each time there is a stay.

- The law and guidance on the disclosure of soft intelligence
 - The MPS decisions and the rationale for non-disclosure of the soft intelligence
 - The opportunity for referral to the MPS Child Abuse Investigation Team
 - The discrepancies in the legal thresholds for information sharing
- 4.22. The legal framework for determining whether the police should disclose such information is set out in the Police Act 1997 and is described below. The fundamentals of the legislation have not changed since 1997, although it has been the subject of a number of court judgements and revised guidance (also described below). At every point over the last 17 years there was an expectation that the vetting of prospective foster carers would lead to the disclosure of information that might point to a risk to vulnerable members of the public.
- 4.23. This is an entirely different issue to the political and public policy debate about the wider legal, procedural and organisational arrangements for vetting those who work with children and vulnerable adults. These arrangements have been subject to a number of legislative and administrative changes in the last decade, reflecting changes in public attitudes and political decisions about how many people who have some form of professional or voluntary contact with children need to be vetted. There have been changes in legislation, which have been accompanied by the creation and abolition of different intermediary bodies standing between the holders of information (such as the police) and potential employers (such as a local authority).³ This is not relevant to the much narrower and specific concerns of this review.

The law and guidance on the disclosure of ‘soft intelligence’

- 4.24. When a person applies to work in a post which will offer substantial access to children, details of criminal convictions and cautions are automatically disclosed. The police service in the area in which the applicant lives is required to make a decision as to whether any other soft intelligence should also be disclosed.
- 4.25. The legislation under which the MPS CEC acted in determining whether details of the 1999 allegations should be disclosed is Section 113 B(4A) of the Police Act 1997.⁴ It requires that when deciding whether a piece of information should be disclosed the police must determine whether it is ‘relevant’ to the applicant’s future work with children and whether it ‘ought’ to be disclosed.
- 4.26. The meaning and weight given to these terms have altered since 1997 as a result of court judgements (referred to below). These judgements have in turn influenced the wording of guidance issued by the Home Office and operational procedures issued by Association of Chief Police Officers (ACPO).
- 4.27. Before 2005, police services relied on ACPO guidance in order to make decisions about the disclosure of soft intelligence. In 2005, following the publication of the findings and recommendations of the Bichard Inquiry into the Soham murders, the Home Office published a circular for Chief Constables on disclosure.⁵ This was not statutory guidance and was intended to be read alongside the existing police guidance. It laid out a number of detailed criteria to help the police decide when to disclose soft intelligence.
- 4.28. Since the implementation of the Police Act 1997, a number of individuals who had been refused employment as a result of soft intelligence disclosed by the police have challenged the decision of the police to disclose the information through the courts. The

³ The history of legislative, policy and organisational changes is set out in detail by Kerry Cleary and Marcus Erooga (in Erooga, Chapter 3).

⁴ The Act was in part amended by the Protection of Freedoms Act 2012.

⁵ Home Office Circular 5/2005 *Criminal Records Bureau: Local Checks by Police Forces*

- most significant of these cases was heard in the Supreme Court in 2009 and will be referred to as *L v Commissioner of Police of the Metropolis*.⁶ It concerned a job applicant who had been prevented from working as a lunchtime supervisor in a school because the MPS had disclosed the fact that two years previously, her adolescent son had been subject to a child protection plan. The professionals involved at the time believed that she had refused to cooperate with the services involved. The MPS had held and retained this information because officers had been involved in local multi-agency child protection meetings, although the job applicant had not been charged with or convicted of an offence against a child.
- 4.29. Whilst the Supreme Court ruled that the MPS had acted legally in disclosing the information, it was critical of the way in which the decision had been reached, though it acknowledged that the procedures and guidance followed had been specifically designed to adhere to the judgements of earlier court cases.
- 4.30. The Supreme Court described how authorities should in future interpret the provisions of Police Act 1997, the meaning of the term ‘relevant’ and the relationship between the relevance of information and whether it ‘ought’ to be disclosed. The court set out how the European Convention on Human Rights (ECHR) should in future impact on decision-making. The key points of its unanimous ruling were that:
- The disclosure of information which affected both the immediate and long term employment prospects of an individual could easily impact on their economic and social standing and would thus have a significant potential impact on the right to a private and family life (and the ECHR therefore had to be taken into consideration)
 - The relevance of information disclosed needed to be extremely carefully weighed
 - The court recognised that the MPS had done so in the case before the court but did not agree with the procedures that it had followed
 - The judgement of the court was that it was not permissible to assume that if information was found to be relevant it should automatically be disclosed. The police should in future consider the legal requirement to determine whether the information ought to be disclosed carefully in every case and record the reasons
 - In doing this, the potential risk to the public must be weighed against the potential adverse negative effect of a disclosure on the person’s right to a private and family life. It was wrong to assume (as had been the case in the previous ACPO and Home Office guidance and procedures) that the former would almost always ‘trump’ the latter.
- 4.31. The Supreme Court judgement also sets out the reasons and wider thinking of a number of the judges. Even those more sympathetic to the police instinct to bend towards the protection of the public emphasised the very severe potential impact on the right to a private and family life of job applicants which could follow from the disclosure of uncorroborated and untested information. These comments, some of which are strongly worded, have understandably influenced subsequent public thinking, guidance and the operational practice of MPS CEC.
- 4.32. In 2010, the government published the findings of a review led by Sunita Mason, who had been appointed by the government as the Independent Advisor for Criminality Information Management.⁷ This review dealt with a number of aspects of public policy in relation to the retention and sharing of criminal records. While it came to no firm

⁶ Judgment R (on the application of L) (FC) (Appellant) v Commissioner of Police of the Metropolis (Respondent). [2009] UKSC 3 On appeal from: [2007] EWCA Civ 168

⁷ Home Office (March 2010) *A Balanced Approach - Independent Review by Sunita Mason Safeguarding the public through the fair and proportionate use of accurate criminal record information*

- conclusions about the sharing of soft intelligence, most of its comments about the sharing of unproven allegations pointed to the need for caution. The review called for the publication of statutory guidance to provide a more detailed framework for future decision-making.
- 4.33. The Mason review did not have a high profile among those involved in day-to-day children's service provision. Although its list of contributors included senior civil servants (from CAFCASS, the Department for Children Schools and Families and the Independent Safeguarding Authority) the published report does not convey any sense of the practicalities of children's service provision. It is not a well-known document among those involved in safeguarding children.⁸
- 4.34. In July 2012, the Home Office published the proposed statutory disclosure guidance⁹ supported by an updated Quality Assurance Framework which gives extremely detailed procedural guidance for police services on the DBS arrangements.¹⁰ The statutory guidance provides a comprehensive statement of the legal and policy framework building on a number of previous documents and the judgement in *L v Commissioner of Police of the Metropolis*. It emphasised that:
- The police must form '*a reasonable belief*' that information other than convictions and cautions is relevant before it may be disclosed and that this is a higher threshold than merely '*considering that it might be or could possibly be*' relevant
 - Information about allegations should not be included '*without taking reasonable steps to ascertain whether they are more likely than not to be true*'
 - *The older the information the more difficult it is to form a reasonable belief that it might be relevant*
 - The reasons for including any soft intelligence in a disclosure should be set out in a full and clear way and the reasons for all decisions must be fully recorded
 - There must be independent scrutiny of difficult cases before the information is disclosed
 - Applicants would have the right to see the information and should have a fair opportunity to comment on information before it is disclosed
 - Disclosure will '*in virtually every case*' impact on the applicant's private life and the reasons must therefore be justified '*in every case*'
 - Any decision to disclose must strike '*a fair balance between the rights of the applicant and the rights of those the disclosure is intended to protect*'
- 4.35. Many of these points had been set out in previous ACPO and Home Office guidance. The four final points are the most significant additions arising from the Supreme Court judgement. It is perhaps understandable in the light of this guidance that the MPS treats the disclosure of soft intelligence with great caution (though the specific wording of the judgement would not have affected the decisions made by the MPS CEC prior to 2010).
- 4.36. This will have been reinforced by the fact that while decisions to disclose information go through several layers of challenge (including challenge from the subject of the information before it is disclosed to a potential employer), neither the law nor the procedural guidance make provision for independent scrutiny of decisions not to disclose.

⁸ Evidenced not least by the fact that apart from the Head of the MPS Character Enquiry Centre none of the contributors to the Serious Case Review (including the author of this report and a number of others with substantial experience in the field of safeguarding) had previously heard of it

⁹ Home Office (July 2012) *Statutory guidance to Chief Officers of Police on providing information for inclusion in enhanced criminal record certificates*

¹⁰ <https://www.gov.uk/government/publications/quality-assurance-framework-version-nine-qaf-v9>

- 4.37. It is important to recognise that while the disclosure and barring arrangements have been subject to close scrutiny since 1997 their design has meant that there has been no easy route whereby a public body or a victim of abuse could challenge a decision not to disclose soft intelligence. No one other than the police will ever be aware of the decision not to disclose. The disclosure arrangements could therefore become more restrictive about the disclosure of soft intelligence, either by a series of deliberate decisions or by drift. There was however no mechanism which would allow for recalibration in the opposite direction. The current Serious Case Review appears to be the first example of a case that has been scrutinised in public in which a decision not to disclose soft intelligence has left children at risk of very serious harm.

The MPS decisions and rationale for non-disclosure of the soft intelligence

- 4.38. MPS CEC staff have contributed openly to the Serious Case Review and it is clear that they acted in good faith and believe that they interpreted law and guidance correctly. The MPS will need to determine whether it should alter its approach in the light of the arguments presented here. As this affects all police forces the arguments should also be presented to ACPO in order to determine whether the practice of the MPS is consistent with that of other police services or whether different decisions would have been made if the foster carers had lived outside London.
- 4.39. The reasons given by the CEC for non-disclosure of information in relation to the 1999 allegation remained consistent. They relate to the test as to whether or not the information was 'relevant' and rely on the following: 1) the original allegation had been anonymous 2) it had not been substantiated and 3) there had been no further adverse information since 1999.
- 4.40. The most recent decision was made in mid-2010. In line with the 2009 Supreme Court judgement the records are fuller. They contain references to the Supreme Court judgement and state that *'the intelligence is 11 years old, anonymous and not supported by any substantial factual or corroborative information.'*
- 4.41. All of these are factors that had been highlighted and repeated in previous versions of the guidance and it was legitimate for the CEC to take them into account. However, there is a strong case that too much weight was attached to them and that other factors should have been considered.
- 4.42. It is clear that the original error rested with whichever part of the MPS did not investigate the anonymous 1999 allegation in the first place. It was not the role of the CEC to reinvestigate the allegation, though it did on at least one occasion bring it to the attention of officers who were trained child abuse investigators. There is a very strong case that the CEC gave too much weight to the uncorroborated nature of the allegation since that was entirely due to the earlier failures of the MPS.
- 4.43. There is an equally strong case that the CEC attached too much weight to the fact that there had been no further allegation since 1999. Unlike violence, substance misuse and other forms of behaviour that typically come to the attention of the CEC, possessing child abuse images is by its nature a solitary, secretive activity that perpetrators usually go to great lengths to keep from others. It is also well established that those who possess child abuse images tend to be 'collectors' and that this is addictive rather than self-limiting behaviour. The fact that 11 years had passed should not have supported the conclusion that the foster carer was likely to have stopped having a sexual interest in children.
- 4.44. Earlier CEC decisions referred to the fact that the original information had contained inaccuracies. This was a spurious concern because the MPS had immediately identified the foster carer's correct details. The argument that this diminished its value lacked logic

- because the informant clearly knew a great deal about the family. It may have been a hypothesis that the allegation was malicious. However, it is difficult to see why a malicious informant would be any more likely to give incorrect details.
- 4.45. All of these factors relate to the question of whether the information was 'relevant'. Because it found that the information was not relevant MPS never progressed to considering whether it 'ought' to have been disclosed. Had it done so, the arguments in favour of disclosure would have been compelling.
- 4.46. The judgement in *L v Commissioner of Police of the Metropolis* indicates that the decision about whether information judged to be relevant should be disclosed needs to be made separately in each case and there should not be a blanket approach which assumes that relevant information would be disclosed. It is hard to imagine any circumstances in which information about the alleged possession of child abuse images ought not to be disclosed to the potential employer of any person applying to work with children. If such a circumstance could ever be envisaged it would certainly not apply in relation to a person applying to foster or adopt.
- 4.47. Foster carers and adopters care for some of the most vulnerable children in society. Such children are more likely than most to have already been abused before they came into local authority care and therefore more likely to be harmed again. Foster carers are expected to spend considerable periods alone with children and to offer them intimate care as part of normal family life, in circumstances where the child will be extremely vulnerable. Doing this is a required part of their responsibility, not a breach of it as would be the case with some who work with children. Daily life in foster care is by design entirely unsupervised by outsiders. Even when made to the required regulatory standard the visits of social workers and others offer only a superficial glimpse into the child's life and cannot guarantee the quality or safety of day-to-day care. The care provided by adopters will usually, after a short period of supervision and support, not be monitored at all.
- 4.48. The courts have been clear that exclusion from an employment opportunity on the basis of sketchy or uncorroborated information may disadvantage a person's social standing and employment prospects and is therefore a potential threat to the right to a private and family life. There is a strong case that this does not apply in the same way to an application to foster or adopt. Those seeking to foster or adopt are not in an open competition for a specific job vacancy. Assessments of fostering applications have common elements (like job interviews) but they are also tailored closely to the circumstances of the individual applicant. Many would-be foster carers withdraw their applications because once they know more about what the role entails they decide it is not a responsibility they want. Many people are unsuccessful in their attempt to become foster carers for very subjective and personal reasons, which remain private unless the applicant chooses to disclose them. Not being approved as a foster carer does not jeopardise a person's prospects of gaining other employment.
- 4.49. Those who want to be foster carers do expect the boundary between their lives and the fostering agency to be very different from that which would normally exist between an employer and employees. Applicants to foster will be asked questions about intimate aspects of their lives and be expected to answer them frankly. Approved foster carers are expected to allow unannounced visits to their home. They give up these aspects of privacy on the basis that the information that is disclosed or discovered during discussions and visits will remain confidential to the fostering agency and others who have a need to know about it. As such they are forfeiting some aspects of their privacy but not their right to respect for a private and family life. The same logic can be said to apply to the disclosure of soft intelligence in the application process.

The opportunity for referral to the Child Abuse Investigation Team

- 4.50. The MPS was asked by the Criminal Record Bureau / Disclosure and Barring Service to provide an updated police check for Hackney Council's fostering service on four occasions. Records of these updated checks show that the information about the allegation was always identified and that on at least two occasions the CEC consulted operational colleagues in the intelligence unit that dealt with public protection and child abuse. It is impossible to be absolutely certain from the records whether this was referred to the intelligence unit to consider taking action or to ensure that the fact of the CEC decision could be properly recorded on MPS intelligence records. However it is certain that at no point did these contacts lead to any action.
- 4.51. It was wrong of the MPS not to have taken the opportunity to begin an investigation of the original allegation each time the information re-emerged through the request for CRB / DBS checks, especially as the renewed request for a check confirmed that the individual was still a foster carer. Whilst it is clear that the CEC does not have an investigative role, there were clear grounds for it to re-refer the case to the local Child Abuse Investigation Team in a way that could have addressed the original failure to investigate the claim.

The discrepancies in the legal thresholds for information sharing

- 4.52. Had a police investigation happened it would have led to information about the allegation being disclosed to the local authorities concerned under normal local safeguarding arrangements. This is because the MPS currently operates two entirely different thresholds for information sharing about soft intelligence that points to a risk to children. One applies when a person is being approved as a foster carer or employed to work with children and when their DBS clearance comes up for renewal: the other applies if there are allegations against a foster carer or a member of the household.
- 4.53. If at any time between 1999 and 2010 there had been an allegation against the foster carer or any other member of his family – even for example an incident of alleged smacking – the police would have shared the information about the 1999 allegation with the local authority in line with national guidance in the normal course of local multi-agency safeguarding arrangements.

Finding and recommendations

- 4.54. Whilst acknowledging the complexities involving the development of the law and guidance supporting the disclosure of soft intelligence, the rationale given by the CEC for non-disclosure placed too much weight on the wording of particular sections of the guidance and gave insufficient consideration to the specific circumstances of the case, the overall intention of legislation and guidance, the vulnerability of children living in foster care and the duty of the police to protect the public.
- 4.55. As the MPS believes that it interpreted the law and guidance correctly it seems very likely that the approach taken in this case would have been applied more widely. The Serious Case Review has therefore recommended that the MPS should revisit other cases in which it has not disclosed soft intelligence where – given a different interpretation of law and guidance – it might have been disclosed. It should also review its current policy and practice on this issue in order to determine whether different judgements about what is 'relevant' can be applied while continuing to act within the law.
- 4.56. The evaluation has highlighted an imbalance in the safeguards that are in place to protect applicants and the wider public from the impact of decisions. A decision to disclose soft intelligence is subject to a number of checks and balances, including allowing the subject of the potential disclosure the opportunity to challenge it in advance of disclosure to the

prospective employer. Under current MPS arrangements, decisions not to disclose soft intelligence are referred to more senior officers depending on the complexity of the case but they are never subject to any independent scrutiny. The Serious Case Review has recommended that the MPS should consider the introduction of such an arrangement.

- 4.57. It is beyond the remit of the Serious Case Review to determine whether the approach taken by the MPS in this case would have been followed by other police services. The Serious Case Review has therefore recommended that the Association of Chief Police Officers should establish this. If other police services have interpreted the case law and the guidance differently then there is probably no need for the Home Office to review its guidance. If other police services have made similar errors then ACPO and the Home Office should be asked to consider reviewing the national guidance.

The local authority response to evidence of sexualised behaviour

- 4.58. One of the children who was abused in the foster home behaved in a very sexualised way while she was there. After she moved to her next placement, she immediately related to the male carer in a sexualised way and for several months showed patterns of behaviour – both at home and at school - that could have been symptomatic of having been sexually abused. The descriptions given are graphic and leave no doubt that her behaviour observed was substantially outside of developmental norms.
- 4.59. The first reports of this behaviour were made in 2003 by the female foster carer to child's allocated social worker. She in turn reported them to a Hackney panel that was considering the child's long-term future. The social worker may have discussed them with her manager but there is no record of this. This was about a year after the child had been placed in the foster home. Despite being documented in the panel minutes, no steps were taken to enquire into the concerns.
- 4.60. In early 2006 (a month after moving to live with permanent carers) the child's behaviour became so concerning that her carers emailed the allocated social worker asking her to arrange therapeutic help, listing sexualised behaviour as one of a number of problems that they were experiencing. As the allocated social worker was away from work temporarily, a duty social worker from the looked after service visited.
- 4.61. The duty worker did not see the email that had highlighted the concerns and treated it as a more general support visit. He made a lengthy record of the visit anticipating that the allocated worker would shortly make a referral to the local CAMHS service. His record contains no specific reference to sexualised behaviour and he told the Serious Case Review that he had no recollection of this being discussed.
- 4.62. Approximately four weeks later, following a discussion with the child's school, the allocated social worker asked the carers for more details of the behaviour. The carers replied stating that *'all the children's teachers commented on their obsession with all things sexual, we are trying to explain to them about inappropriate behaviour and the like but I am not sure how to handle it really. Also all three children abuse themselves. In fairly minor ways at the moment'*. Further detailed descriptions follow together with comments on the practicality of the children being seen by a therapist either in London or locally. The social worker noted that she had been in contact with the children's school and refers to staff comments that this child *'tells lies and makes up stories that are violent or obscene'* and that she had drawn a *'scary and obscene'* picture.
- 4.63. This sharing of information and concerns took place in the days leading up to the child's looked after review meeting (the first one since the placement had been made) but they were not referred to in the record of the meeting, which focused on wider concerns about the children's behaviour.

- 4.64. In late 2006, after a change in the allocated social worker there was an unsuccessful attempt to arrange for support at the local CAMHS service, which foundered over discussions about what sort of provision was needed for the children and because (according to the CAMHS record) the allocated social worker cancelled several appointments at the last minute.
- 4.65. In mid-2007 after a further change in social worker a more concerted and eventually successful attempt was made to arrange therapeutic services for the children. This resulted in a long period of contact with a specialist counselling service. This work focused on wider support for the placement and was never intended to address the concerns about sexualised behaviour.
- 4.66. Over time the concerns about sexualised behaviour became less prominent, though there were a small number of further incidents involving the child and, separately, one of her siblings. These were enquired into by local services to establish what had happened but there was never any further enquiry into the possible origins of the behaviour. None of the children in this sibling group alleged sexual abuse until they were contacted during the police investigation in late 2012.
- 4.67. The female foster carer always asserted that the behaviour had been copied and learnt from the child's birth mother. This explanation was accepted and repeated uncritically in the social care records. In fact the child's records shows that the child and her siblings had experienced severe neglect and emotional abuse before they came into care, but there is no evidence that they suffered sexual abuse, or that this had ever been suspected. Despite the disparity between the account given by the foster carer and the children's records, no one questioned why the sexualised behaviour had first been observed a year into the placement with the foster family, challenged the foster mother's account or, at least in the written records, that anyone showed any curiosity about its origins.
- 4.68. There were four different Hackney services involved with the children and the foster carers during this period, each with a different level of knowledge of the problem.
- 4.69. The fostering service was supervising the foster carers where the abuse had taken place. Concerns about the child's provocative and precocious behaviour were discussed in detail at the annual fostering review in May 2005 during which the female foster carer repeated her account of its origins and described in detail how she was addressing the concerns and assisting the child. The high regard in which the foster carers were held in the service appears to have prevented anyone from thinking that the behaviour might be the result of abuse in the home. The relationship between the foster carers and the service and the limitations of the annual foster carer reviews are discussed in Section 6.
- 4.70. A member of the borough's therapeutic service who was involved in order to advise the court on the care plan for the child and her siblings focused specifically on that task. She told the Serious Case Review that she had no recollection of this concern being raised.
- 4.71. Another social worker in the looked after children's service had the task of seeking a permanent family for the child and then supporting her subsequent carers. She told the Serious Case Review that she was aware of the sexualised behaviour which, although very marked, was seen as just one troubling feature among the children's many difficulties. When asked about the lack of response, she reported that the local authority 'would' have responded positively to concerns about sexualised behaviour. She could not explain, however, why the local authority had not done in this case other than to state that the child had had a number of different allocated social workers. She appears to have

- felt that it would have been the responsibility of the child's allocated social worker to take action.
- 4.72. It did not occur to the allocated social workers or managers in the looked after children's service that the child was being abused while she was living in the foster home. Their inability to evaluate the concerns properly is in part a reflection of the very fragmented social work provision that was made for this child and her siblings between 2002 and 2006. During this period the children had seven changes of allocated social worker, some at critical periods in the children's lives including in the period shortly before their move to a permanent placement. There was drift and delay in many of the tasks undertaken by the local authority.
- 4.73. Some of the work undertaken was below the expected professional standard. Hackney terminated the employment of one agency social worker because of the poor quality of her work. For example the Form E which she wrote (which described the children to prospective carers) was identified as having seriously misrepresented their behaviour and needs. When they moved to their permanent home they demonstrated very severe behavioural and emotional problems which far exceeded the level that the local authority or the new carers had anticipated.
- 4.74. This meant that the carers struggled to meet the children's needs and workers responsible for the case were concerned with the overall viability of the placement. In this context the problem of sexualised behaviour was viewed as one part of a range of other severe difficulties which continued for several years.
- 4.75. In 2005 – 2006 the local authority was implementing the transfer from paper to electronic records. It is not possible to establish exactly when or how the records of this case were scanned to the computerised system but it is very likely that the transfer to a new record keeping system reduced the ability of staff to review previous records and keep significant previous events and concerns in mind when working with the children. It certainly would have been more difficult for staff beginning to work with the family in 2007 to understand that concerns about sexualised behaviour were part of a pattern that had begun in 2003 because the records would not have been to hand.
- 4.76. Other young people and carers told the Serious Case Review that the majority of the social workers who worked with them at this time had only a very limited knowledge of the children and their histories. With few exceptions they believed that social workers had not read children's files (and sometimes note even key documents) before they first visited them. As a result they relied heavily on limited briefings from colleagues and information from carers. This again increased the likelihood of knowledge of significant events being lost or not fully understood.
- 4.77. In its individual management review the local authority has recognised that social workers struggled to work constructively when a child showed sexualised behaviour. This problem is not unique to this case, to social workers or to Hackney. The local authority management review makes a recommendation as to how this can be addressed which the Serious Case Review endorses.
- 4.78. Repeated changes in social work staff worsened difficulties. There have been significant changes in the standards of children's social care provision in Hackney since the episodes under review. Hackney's current organisational arrangements for the delivery of services to looked after children place responsibility for each child's case with a multi-disciplinary and mixed skill unit consisting of a small number of staff. One of the strongest arguments for this model of service delivery is that holding knowledge about and responsibility for the child in a small team rather than an individual worker reduces the likelihood that

crucial elements of children's histories will become lost. The service is also designed to ensure that all team members will have a shared understanding of key concerns.

- 4.79. The service to this child and her siblings would have been much better if Hackney had been able to recruit and retain skilled and knowledgeable social workers between 2002 and 2006. All local authorities – including Hackney – struggle periodically to recruit. The findings of this evaluation do not add to the knowledge that senior managers in all local authorities have about the value of attracting, retaining and developing the skills and knowledge of good staff. Nor will they add to the steps already in place by employers, training establishments and central government to achieve these objectives. The review therefore makes no specific recommendation in relation to this.

Photographs given to a family that subsequently cared for one of the children

- 4.80. A couple who became the permanent carers of a child who is now known to have been abused by the male foster carer received photographs at around the time when she joined their family which caused them concern. Brief descriptions of the photographs are given in Section 3.
- 4.81. The couple thought carefully about the photographs and decided not to mention their misgivings with the local authority. There were a number of reasons for this. The nature of the photographs made them unsure. Echoing the finding in the previous section of the report, it did not occur to them that the foster carer might have been abusing the child. They were more concerned that his action in taking the photographs might have left him open to allegations. Their experience at the time was that the child liked the foster carer and appeared to be very comfortable in his presence.
- 4.82. It was clear to the couple that the child's foster carers were held in very high regard by the local authority. At that point the couple were relying on the local authority to report favourably on their own care of the child in legal proceedings and – despite clearly being competent and articulate – they felt vulnerable. They felt that if they criticised the foster carers they might be perceived as having questioned the judgement of the local authority and this put them off discussing the photographs.
- 4.83. They also took some account of the fact that the next child who moved into the foster home was a much older adolescent who would be able to determine for herself if she wanted to be photographed and if so how. After this they had only limited further contact with the local authority.
- 4.84. There is no evidence that any children (either looked after or not) were abused after this episode because it came towards the end of the period when the foster carers had children placed with them. However it underlines the importance of all those involved with looked after children having an understanding that they may be at risk from professionals who are charged with caring for them. It also underlines the value of foster carers' annual reviews taking a full account of information from the adults who care for children after they have left a foster home. This is discussed further in section 6.

The response to an allegation of abuse made in a counselling session

- 4.85. In 2010 a GP referred one of the victims (then a young adult) to a counsellor because she had told the doctor that she felt angry and upset about events in her life. In counselling sessions she alleged that she had been sexually abused by the male foster carer, approximately eight years earlier. The counsellor discussed whether she wanted to tell her current carer and how they might approach doing this. After one more session the young person stopped attending. The counsellor informed her supervisor and told the GP

- that the young person had stopped attending. At this point the young person was living away from Hackney and away from the area in which the foster carers lived.
- 4.86. None of these professionals informed an agency that could have investigated the circumstances further, though they cannot have known whether the alleged perpetrator was still a foster carer or had contact with other children who might have been at risk. No action appears to have been taken over the fact that the victim stopped attending the counselling though there were a number of aspects of her circumstances that made her potentially vulnerable.
- 4.87. The Serious Case Review has sought through the local designated health professionals to establish why, at the very least, no one took advice from a named safeguarding specialist or from the local authority about the potential risks to other children. It has recognised that whilst the young person herself was by now not at risk from the foster carer, he might have been in contact with other children. He was in fact still fostering an older adolescent who has said that she has not been abused.
- 4.88. These enquiries have established that the General Practitioner involved was not informed that the young person had made an allegation of abuse. It appears that the contract for the counselling service did not specify that information about risk to patients should be provided to the referring professional. The counsellor has been contacted by a member of the local NHS Local Area Team but has not been prepared to provide an account of her involvement or the reasons for her actions and decisions. It has therefore not been possible to obtain any further learning from this episode.
- 4.89. The Clinical Commissioning Group in the area where this incident occurred has reminded GPs and other local health professionals of the need to refer allegations of abuse in line with local safeguarding procedures. The NHS Local Area Team has also agreed that a recommendation should be made to NHS England (which now has oversight of the safeguarding activity of GP practices) that in future GP contracted counselling services include as part of their service specification a clear expectations that any safeguarding concerns will be dealt with in accordance with expected standards of good child protection practice.

Wider lessons for safeguarding services about the nature of child sexual abuse, the experiences of children who have been abused and the way in which perpetrators operate

- 4.90. The Serious Case Review has identified wider learning about the nature of child sexual abuse, the experiences of children who have been sexually abused, the way in which perpetrators operate and the vulnerability of children in care. It considers a number of factors which make it more difficult to identify and prevent sexual abuse:
- The secretive nature of sexual abuse
 - The difficulty for children of understanding and talking about abuse
 - The behaviour of perpetrators
 - The vulnerability of looked after children.
- 4.91. These challenges are not new or unique to this Serious Case Review. Describing them does not diminish the responsibility of professionals to combat this abuse, but sets a context to understand why this can be so difficult.

Secrecy

- 4.92. The sexual abuse of the children by the male foster carer was deliberate, planned, and secretive. There is evidence pointing to the strong likelihood that the female foster carer knew that at least one child was being abused and that others were therefore at risk. Two

family members have said that she was shown photographs of a foster child in around 1999 which pointed to entirely inappropriate behaviour towards the child, but that she did not act to protect her. The male foster carer told the Serious Case Review that his wife knew about his sexual interest in children before they applied to foster and that discussions about child sexual abuse continued between them throughout the period when they fostered.

- 4.93. Throughout the period under review the female foster carer had sexual relationships with a number of male visitors to the family home. She would have known that if this had been discovered her conduct would have led to her deregistration as a foster carer, loss of income and status. Even if she did not know about the sexual abuse of the children, the female foster carer had her own motives for hiding knowledge about sexual activity in the household from professionals.
- 4.94. Between 1999 and 2008 the male foster carer largely kept in the background as far as professionals were concerned. In contrast, the female foster carer was assertive and combative towards professionals. She used a number of approaches to undermine the credibility of the workers who raised concerns about the standards of care provided to the foster children. This included repeatedly criticising the competence and reliability of social workers in front of the children and making complaints (both formal and informal to other professionals). This in turn made it less likely that any of the victims would feel able to confide in the professionals who visited the household.

The difficulty of understanding and talking about sexual abuse

- 4.95. Child sexual abuse has been described as being '*not an act or an incident but the corruption of a relationship*' in which the child is exposed to the offender's '*distorted attitudes and beliefs, as well as his abusive behaviours*'.¹¹ Sexually abusive behaviour shapes the way that the victim understands his or her experience and is able to respond. As a result victims of sexual abuse almost always find it extremely difficult to talk about what has happened, both at the time of the abuse and commonly for many years after. This is very typical of the experience of children who have been abused by a professional working with them. A recent study of perpetrators who had abused children in educational, care or religious settings found that on average more than 14 years elapsed between the offence committed and prosecution of the offender.¹²
- 4.96. According to the foster children's testimony, the male foster carer used physical force to coerce his victims and threatened violence if they told anyone. None of the victims knew that others were being abused and all felt isolated. All were very young when the abuse started and the majority had special educational needs or a learning disability.
- 4.97. Aspects of their experience as looked after children made them less likely to tell. Some of the victims believed that what they were experiencing was 'normal' because it was similar to their experience before coming into care. Most victims believed that they would get into trouble and be split up from their siblings if they told anyone what was happening. For children who had already been separated from parents and other siblings this was an extremely powerful threat. It is not a surprise that the children were unable to speak about what had happened for several years, regardless of how well they were looked after subsequently and despite the fact that a number were asked explicitly if anything like this had happened.

¹¹ R Tucker and J Still, (2009) *Staying Safe – Focused intervention for children and young people who live in families who have been affected by sexual abuse* Lucy Faithfull Foundation

¹² See M Erooga (ed) 2012 *Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working With Them* (Wiley) page 66. This average is based on a sample of perpetrators undergoing treatment. It does not take account of the large proportion of cases where there is no allegation or investigation.

- 4.98. One victim (who was not in care) told the Serious Case Review that she had actively thought about confiding in a trusted teacher about what was happening. She drew back from doing so because she felt that she would not be believed, more so because she knew that the perpetrator was a foster carer.
- 4.99. Taken into account alongside the actions of members of the foster family to maintain the secrecy surrounding the abuse, this underlines how extremely difficult it would have been for information about the abuse to be disclosed, even when the victims had possible opportunities to confide in someone. A number of the children had extended counselling or therapy sessions away from carers and social workers, including sessions at a very highly regarded placement support service. Though it was not the objective of this work to identify past sexual abuse, many of the children did spend long periods having one to one contact with counsellors and others where they might in theory have disclosed what had happened.
- 4.100. When two of the victims did speak about what had happened they chose to tell people in their private lives whom they had known and trusted for some time. The first young person who did speak to a counsellor (eight years after she had left the foster home) did not want her current carers to know and withdrew from the counselling sessions after discussions about how she might think about telling them.
- 4.101. The experience that the majority of the children had of contact with social workers and other professionals also made it less rather than more likely that they would be able to speak about what had happened. This is considered further in Section 6 below.

How the behaviour of sexual abuse perpetrators is seen and understood

- 4.102. The behaviour of perpetrators of sexual abuse makes the risk they pose harder for the public and professionals to identify. The motivation to sexually abuse children stems from a variety of factors. As well as having a sexual component there is always a motivation rooted in the perpetrator's emotional needs. Emotional drives to abuse may reflect the person's arrested emotional development, or the need to feel powerful and controlling or to re-enact a childhood trauma.¹³ They can sometimes be manifest in positive, apparently considerate behaviour towards children, including qualities that would be desirable in a foster carer.
- 4.103. Some abusers relate well to children and enjoy their company because they are seeking to meet their own childish needs.¹⁴ In this case, the male foster carer was observed to be the partner who engaged in constructive and enjoyable leisure activities with his own family and with the foster children. His abusive acts are unlikely to have gone undetected for so long had he not at times been involved with the children in ways which seemed beneficial and positive.
- 4.104. Researchers and clinicians working with perpetrators view the sexual abuse of children as part of a planned pattern of behaviour which is cyclical in nature. The diagram in Appendix V is one way of illustrating this.¹⁵
- 4.105. The cycle of abusive behaviour includes times when the perpetrator is assaulting children. It also includes periods of targeting, planning and manipulation - both of the child and those who could protect the child. It will include actions designed to prevent disclosure; actions that allow the perpetrator to think that the impact of abuse on the child has been minimal in order to 'justify' the abusive act and overcome feelings of guilt and acts of

¹³ Erooga (2012) Chapter 1

¹⁴ Finkelhor termed this 'emotional congruence' and described it as one of the pre-conditions for sexually abusive behaviour. See D Finkelhor (1984) *Child Sexual Abuse – New Theory and Research*, Free Press New York

¹⁵ R Tucker and J Still, (op cit) Lucy Faithfull Foundation

compensatory behaviour towards the child victim. During most of the phases of this cycle the offender's behaviour may not look like the actions of a person who poses a risk to children.

Action taken by the perpetrator to 'groom' or 'condition' professionals

- 4.106. Perpetrators take deliberate steps to make it more likely that they will succeed in abusing a child and less likely that the abuse will be discovered. This is commonly referred to as 'grooming' or 'conditioning'.¹⁶ It applies in different ways to the victim and to the other professionals involved with the child. Grooming has been defined as being '*the process by which a person prepares a child, significant adults and the environment for the abuse of this child. Specific goals include gaining access to the child, gaining the child's compliance and maintaining the child's secrecy to avoid disclosure*'.¹⁷
- 4.107. When the perpetrator is working with children in a professional capacity, conditioning the other professionals who are working with the child is of particular importance. This is because the child and the perpetrator are likely to be in reasonably frequent contact with a range of other professionals, with the perpetrator being part of a team whose explicit goal is to safeguard and promote the welfare of the child. Child protection and safeguarding should be regular features of discussions between these professionals. This makes the perpetrator's presentation to other professionals particularly critical in reducing the risk that abuse will be identified.
- 4.108. Erooga has recently reported on research into the ways in which perpetrators who were working in professional roles with children behaved towards those around them.¹⁸ These are described as a variety of what are termed 'manipulation styles'. Section 6 of this report describes in detail the strategies used by the foster carers to reduce the likelihood that their behaviour would be discovered.

An explicit recognition that children who are in public care need to be kept safe

- 4.109. One of the children showed a very high level of sexualised behaviour, which was noted by teachers and social workers. The Serious Case Review has considered whether there may have been an underlying assumption among professionals that this child was not being abused in her foster home because she and the others placed there were safe, either because they were in public care or more specifically because they were in foster care. It is unlikely that anyone would consciously hold this belief or actively promote it. However none of the professionals involved ever hypothesised or suggested that abuse by the foster carer might explain the child's difficulties.
- 4.110. There are two lessons. The first is that it is important for organisations to enable staff to consider the possibility of alternative, possibly unpalatable, explanations for children's problems. This applies to a wide range of issues.
- 4.111. The second is that it is important for organisations to help their staff remember that even though it is unusual a child who is looked after by the local authority might be abused by a professional carer. The number of allegations and proven cases of sexual abuse in foster care is very small.¹⁹ However this case history demonstrates that if a person who is

¹⁶ Whilst the value of the terms grooming, conditioning and manipulation are beyond doubt the remainder of the report has avoided their repeated use on the grounds that there is an advantage in describing the behaviour of the foster carers in detail and a danger in repeatedly using any shorthand term to the point where it loses descriptive power and stops rather than encourages critical thought.

¹⁷ Craven et al (2006) Sexual Grooming of Children: Review of Literature and Theoretical Considerations, *Journal of Sexual Aggression* 13(2) cited in Erooga (op cit). Whilst the value of the terms is beyond doubt the remainder of the report

¹⁸ Erooga (op cit) pages 90-97

¹⁹ Nina Biehal, (2014) 'Maltreatment in Foster Care: A review of the evidence', *Child Abuse Review* Vol. 23: 48-60

determined to commit sexual abuse does become a foster carer his or her activities may be very difficult to detect and the harm done to the victims may be considerable.

The importance of wider work to reduce the risk of children being re-victimised

- 4.112. Even if abuse by foster carers is rare, there are additional and much more generally applicable reasons why professionals need to remember how vulnerable children in public care are and why service provision needs to actively promote measures to keep them safe. This is important because of the need to reduce the likelihood of children being re-victimised or becoming victims of other forms of abuse or harm (sometimes referred to in research as ‘poly-victims’).²⁰
- 4.113. Poly-victimisation is particularly harmful to children’s long-term health and development. Research has found that poly-victims *‘suffer the most serious kinds of victimisation...and had suffered considerably more other life time adversities (such as major illnesses, accidents or family problems) and were the most distressed’*. In contrast to being the victim of a single form of abuse, *‘poly victimisation is the thing most closely associated with mental health problems and bad outcome’*.²¹
- 4.114. This has obvious relevance for children in public care, very many of whom have suffered abuse (and often more than one form of abuse) before coming into care. Common practical shortcomings in the care system can add to the risk of re-victimisation. For example looked after children sometimes experience multiple moves and are required to live in unfamiliar locations. Changes in peer group and the loss of familiar sources of support reduce the number of people for the child to confide in reduce resilience and may increase risk.
- 4.115. If children in care are more vulnerable to re-abuse or to other forms of abuse and poly-victimisation is particularly harmful it follows that work with looked after children should focus on reducing the likelihood of all forms of potential further victimisation. Emphasising that looked after children are not necessarily safe just because they are in public care does not require that professionals place undue emphasis on the likelihood that a looked after child will be sexually abused by a foster carer, which is low. Protecting against sexual abuse should be considered as part of the wider work to be undertaken with all looked after children to reduce the risk of any further victimisation.

Educational work to reduce the likelihood of further sexual abuse

- 4.116. There is also a strong case that children who are known to have been sexually abused need specific help. Although three of the children who are the subject of this review were known to have been victims of sexual abuse before they came into care, they received no educational information or further preventative work to reduce the risk of further sexual abuse whilst they were in care. There is a professional consensus that after a period of ‘watchful waiting’, observation and screening, almost all children who have been sexually abused benefit from short term psychological assessment, support and educational work in the period following the discovery of abuse.²² Such programmes are now much more

²⁰ David Finkelhor (2008) *Childhood Victimization: Violence, Crime and Abuse in the Lives of Young People*, Oxford. Finkelhor’s research takes into account experiences of abuse (as defined within traditional child protection processes) as well as other forms of victimisation such as bullying, neglect, assault by other young people, or being a victim of crime. The definition of poly-victim used in the study was for a young person to have experienced four types of victimisation in a 12 month period. The prefix ‘poly’ is favoured because it conveys the idea of a young person being subject to a number of different types of abusive or harmful experience, rather than multiple instances of the same type of harm.

²¹ Finkelhor (op cit page 36)

²² The Serious Case Review has drawn on a summary of research findings on treatment approaches to child sexual abuse provided by Tara Weeramanthri, Child & Adolescent Psychiatrist, South London and Maudsley NHS Foundation Trust. http://www.londonscb.gov.uk/files/conference07/6b_tara_weeramanthri.ppt An updated version of the presentation can be obtained from the author Tara.Weeramanthri@slam.nhs.uk

widely available then they were 15 years ago and there is a strong case that their use should be actively considered for all looked after children who are known or suspected to have been sexually abused.

- 4.117. The local authority has made recommendations in relation both to the need for specific educational work to take place with children who have been victims of sexual abuse and also for further consideration to be given to the need to protect all looked after children from further victimisation. The Serious Case Review endorses these proposed actions.

5. Recommendations

5.1 Recommendations from the Serious Case Review overview report

Allegation of possession of child abuse images

1. The Metropolitan Police Service should consider what further action it can take to determine why the allegation made in 1999 that the foster carer possessed images of child abuse was not investigated properly.
2. The Metropolitan Police Service should provide assurance, supported by evidence, to all London LSCBs that it consistently investigates allegations of the possession, creation and distribution of child abuse images and that it works effectively with local authorities and other partners to safeguard children in such cases.

Disclosure of 'soft intelligence' under the Police Act 1997

3. The Metropolitan Police Service should undertake a dip sample audit of cases in which it has not disclosed 'soft intelligence' as part of CRB / DBS checks in the last five years. This audit will determine whether, in the light of the findings of the Serious Case Review, additional information should have been disclosed and whether further scrutiny of a wider sample of cases is required.
4. The Metropolitan Police Service should review its current policy and practice in relation to the disclosure of 'soft intelligence' in order to determine whether a different interpretation of the law, associated case law and guidance should be applied.
5. The Metropolitan Police Service should consider the introduction of independent scrutiny of decisions not to disclose soft intelligence.
6. The Association of Chief Police Officers (ACPO) should establish from other police services whether the approach taken by the MPS to the disclosure of 'soft intelligence' in the course of DBS disclosure has been taken more widely and if so determine what further action is necessary. Subject to this wider enquiry ACPO should consider whether it is necessary to ask the Home Office to review its current guidance on the disclosure of soft intelligence.

GP contracting of counselling services

7. NHS England should ensure that in future GP contracts for counselling services include appropriate reference to safeguarding procedures for children and vulnerable adults so that allegations made by vulnerable patients are reported to those with the power to investigate them.

Role of City and Hackney Safeguarding Children Board

8. CHSCB should monitor the actions taken by Hackney Council to implement the recommendations of the independent review of its fostering services.
9. CHSCB should monitor the effectiveness of the work done by agencies to safeguard and promote the welfare of looked after children and challenge them when the outcomes are not in line with the aspirations of the LSCB, the local authority and the corporate parenting strategy.
10. CHSCB should monitor the implementation of the recommendations made by member agencies in individual management reviews submitted to the Serious Case Review.

5.2 Recommendations from individual management reviews

Metropolitan Police Service

- a) Supervision - The MPS Specialist Crime and Operations (SC&O) 26 Character Enquiry Centre (CEC) should carry out a dip sample of cases concerning DBS applications, to ensure that all safeguarding issues in relation to both the safeguarding of children and vulnerable adults is consistently carried out in accordance with CEC's role and QUAFFS Home Office Standard Operating Procedures.
- b) Supervision - It is recommended that the MPS Sexual Offences, Exploitation and Child Abuse Command (SOECAC) carry out a dip sample of the time taken between the initial reporting of child protection offences, allocation and action to investigate the allegation, to show compliance with Standard Operating Procedures. This is to ensure that there is no unnecessary delay that could jeopardise a potential prosecution by inactivity and to display support and commitment of the information supplied by a victim.

Health Service Provider for looked after children

- a) Health assessments to be proactively managed in advance and a reminder sent prior to the assessment taking place. Continue to monitor the timeliness of reviews on a monthly basis as part of performance management.
- b) To continue allocating all Looked after Children (LAC) by caseload to a specific LAC nurse to ensure that all actions from a health assessments are followed up. An audit will be undertaken in 6 months to ensure recommendations from health assessments are followed-up
- c) Discussions to take place with children social care to ensure that the LAC minutes are sent to the Looked after Children Health Team (LACHT) to be placed in the child's records. An audit will be undertaken in 6 months to assess improvement
- d) Increase the number of LAC having Strengths and Difficulties Questionnaires and the scored outcomes shared with LACHT. An audit will be undertaken in 6 months to ensure improvement.
- e) The views of all children (taking into account the age, cognitive ability etc.) will be sought and where appropriate they will be seen on their own without the foster carer present. This will be recorded in the health record at every contact and audited annually for completeness.

Hackney Children's Social Care

- a) Hackney CSC should ensure that all staff working with LAC and their carers, including those in placement commissioning and support services such as fostering are aware of and equipped to respond to the specific vulnerabilities of LAC. The desired outcome is that plans for all LAC address their need for on-going protection from abuse.
- b) Hackney CSC should ensure that all staff working with children have a sound understanding of children's sexual development, are able to recognise sexual behaviours that are outside of the norm and have the skills to develop thorough, informed and considered assessments of the potential reasons for any unusual

behaviour. The desired outcome is that practitioners can accurately identify potential or actual risks and put protective measures in place.

- c) Hackney CSC should ensure that the individual therapeutic needs of LAC who have a history of sexual abuse are fully considered and addressed. The desired outcome is that children receive appropriate support at the right time to minimise the impact of past abuse and reduce future vulnerability.
- d) Hackney CSC should ensure that all practitioners within the service including those in placement commissioning and support services such as fostering have a sound understanding of the range of characteristics, motivations and behaviours of people who seek to sexually abuse children. The desired outcome is that practitioners are more able to identify people who may pose a risk and take protective action.
- e) Hackney CSC should ensure that all staff including those in placement commissioning and support services such as fostering are able to identify and respond to dangerous dynamics within professional relationships. The desired outcome is that staff are able to minimise the potential for dangerous professional dynamics to undermine the effectiveness of services to safeguard children. This should include consideration of professional roles and boundaries (particularly in respect of relationships between social workers and foster carers), the role of reflective supervision, healthy professional challenge and the value of alternative perspectives.
- f) Hackney CSC fostering service and the Fostering Panel, should ensure that all assessments of foster carers are thorough, robust and appropriately challenging with information being sought from a wide range of sources whilst placing limited reliance on DBS checks. The desired outcome is that there is a high level of assurance on judgements about the ability of prospective carers to provide safe care.
- g) Hackney CSC's Independent Reviewing Unit should ensure that annual reviews of foster carers are robust, thorough and challenging. The desired outcome is that reviews provide regular scrutiny of arrangements with any shortfalls in the care being provided to children being identified and addressed.
- h) Hackney CSC should undertake regular audits of fostering cases. The desired outcome is that managers can assure themselves that good practice standards are embedded throughout the service and that practice is compliant with regulations and procedures.
- i) Hackney CSC should ensure that all staff are aware of the limitations of previous recording systems. The desired outcome is that assessments and interventions are not based on potentially inaccurate assumptions about previous involvement with the service.

6. Historical evaluation of safeguarding arrangements for looked after children in Hackney

- 6.1. This chapter sets out the detailed evaluation of professional practice in respect of the safeguarding of children who were looked after by Hackney Council and in foster care between 1997 and 2008. Although much of the information contained in this analysis is historical there are two reasons to publish a very detailed account. Firstly to ensure that the young people who were victims of abuse can understand how the perpetrator became and remained a foster carer. Secondly because a number of the factors that contributed to the shortcomings in services may apply to other fostering services today (both local authority services and independent fostering providers). As well as assisting Hackney Council and its partners this may assist in making other services safer.

The context

- 6.2. Between 1996 and 2006 important aspects of Hackney's social care provision failed to meet the standard needed by service users and expected by statutory guidance. Findings on this were documented in a number of published inspection reports.²³
- 6.3. During this period Hackney saw several changes in senior managers and directors with responsibilities for social care services. There were a number of reorganisations of services designed to address different aspects of the difficulties. Staff and former staff who spoke to the Serious Case Review provided accounts of the difficulties of working in this environment and of the impact – both good and bad - of the many organisational changes.
- 6.4. Whilst well intentioned some evidently had a very negative effect. One major restructuring exercise, which took place in the late 1990s, redrew social work team responsibilities and required the transfer of large numbers of cases between teams. It left managers struggling to identify the cases for which their staff had responsibility. Within months the authority had been made the subject of a statutory direction to improve from the Secretary of State at the Department of Health.
- 6.5. At other points there is evidence that changes introduced by senior managers had a very positive impact on aspects of service delivery, including the fostering service. Some of these managers did not stay in Hackney for long and not all of the improvement that had been achieved could be sustained. In 2002 an inspection report identified that 14% of children looked after and 33% of children who were subject to child protection plans had no allocated social worker. The inspection team noted that some looked after children teams had been auditing cases in order to prioritise the limited social work resource.
- 6.6. The independent inspection in 2002 noted that there had been much improvement but that *'staff were addressing the legacy of many cases where the quality of planning and service had been unacceptable'*. As a result social workers were *'on the back foot when seeking to secure the welfare of children and young people through the courts'*.
- 6.7. As late as 2006 the Audit Commission noted that 25% of social work posts in the local authority were filled by agency staff, though this was a reduction from the previous level of 40%.
- 6.8. The organisational difficulties described adversely affected the work that front line staff and managers carried out with the foster carers and the children that they looked after.

²³ Social Services Inspectorate, Ofsted and Audit Commission inspection reports published between 1998 and 2006

The work with a number of the children who are the subject of this review prior to 2007 reflects these concerns.

- 6.9. Between 1995 and 2002 the policy of redeploying unqualified staff from residential homes into social work posts led to further weaknesses in services.
- 6.10. In 2006 a major remodelling of the way that social work services were delivered in Hackney was initiated.²⁴ This involved social workers and other professionals being organised into small social work units under the leadership of a consultant social worker. In contrast to some earlier reorganisations the implementation of this model was by design gradual so that social work units were only formed and allowed to take on responsibility for cases when managers believed that they could operate safely and effectively.
- 6.11. The priority was to remodel the local authority's first referral and assessment service and services for children in need or protection. Social work units for looked after children and leaving care services took responsibility for the children who are the subject of this review in 2007 and 2008. The evidence from material reviewed after this date is that aspects of the services provided to the children had improved. For example there is more evidence of contact with young people and evidence of discussions to establish their wishes and feelings and involve them in decision-making. There is less drift in case planning and recording of involvement is more comprehensive.
- 6.12. Tensions between the local authority and some of the permanent carers of the children who are the subject of the Serious Case Review had existed for some time and continued. The reasons for this can be traced to the unhappy legacy of previous poor service provision.
- 6.13. Remodelling began in the fostering service in 2010 – 2011. There are sound reasons in theory why it should have a very positive impact. The council's own review of fostering services (referred to below) indicates that there remain areas in which it has yet to have full effect.

The recruitment and assessment of the foster carers

Actions and decisions of the local authority 1995 - 97

- 6.14. The Serious Case Review has evaluated the recruitment and assessment of the foster carers in order to consider whether it met the standards that should have applied at the time. The checks and references made by Hackney were in keeping with the contemporary fostering regulations. Different approaches now apply. For example, reservations in relation to the applicant's own children were explored during visits to the family, observation of the young person concerned and attempted discussions. It is now normal practice in many fostering agencies to seek references from the schools attended by an applicant's child and other agencies that know them, but that was not the case in 1996.
- 6.15. There are however a number of aspects of the assessment, which based on the standards that should have prevailed at the time and a limited degree of professional curiosity, ought to have been explored further.
- 6.16. The mother claimed that she was a registered child minder. In fact the local authority where the applicants lived has no record of this and it was not confirmed in the reference that the local authority provided. Since her motivation to foster and the credibility of her application were linked to a considerable degree to her reported experience as a child

²⁴ S Goodman and I Trowler (eds) (2012) *Social Work Reclaimed*, Jessica Kingsley; London

- minder, establishing that she had never been registered or had at one point been registered but was perhaps continuing to child mind without formal registration would have caused serious concerns.
- 6.17. There are also discrepancies in accounts about whether the couple had previously applied to foster. The original fostering assessment stated that the couple had previously been ‘turned down’ from fostering by their own local authority on the grounds that they had too many children. The existence of an earlier application was consistent with information provided by a victim of abuse who lived nearby. She told the Serious Case Review that neighbours had believed that the couple had been rejected because of a concerning incident in relation to the care of one of the children (not related to sexual abuse).
- 6.18. The records of the foster carers’ local authority however only note an application to foster with that authority in 2005 (coinciding with a point when the couple’s relationship with Hackney began to deteriorate because Hackney wanted to reduce the number of children that they could foster). It remains unclear if any earlier application had been made. If the previous application had not in fact been made the couple’s dishonesty would have caused concern. If it had, the circumstances might have been equally concerning.
- 6.19. As the female applicant had spoken about working with a voluntary organisation with children and their families it should have seemed natural to check the details, particularly as there were reservations about her attitude and ability to work with families and professionals. She mentioned that the organisation worked with cases where there had been sexual abuse. There is a danger of attributing more significance to this remark in hindsight than it deserves. However it is a surprisingly explicit comment that could have been the subject of a very useful discussion.
- 6.20. The fostering assessment included only very limited discussion of several other obviously important areas, particularly the male applicant’s history of having been in care. He stated that he had been in foster care but it is not clear why his period in care had not been highlighted in the local authority check - since his family had lived in the same local authority area. He was very vague about having been offered the chance of going either to an independent school or a borstal. These details could easily have been established. The male applicant said that he did not know the details but in fact it is clear from later events that he had very clear and specific memories about events in his childhood which he shared readily when it suited him.
- 6.21. It is surprising that no consideration was given to the possibility that the male applicant might have been abused during that time or that at the very least the quality of his experience in care might have been very poor. At the time of this assessment there was very substantial concern and professional discussion about the risks of abuse in out of family care.²⁵ For example in 1992 the Warner report (triggered by the systematic abuse of children in residential care in Leicestershire) had set out how in future recruitment of staff working with children should take account of the applicant’s history, personality and attitudes.²⁶ At exactly the time when the assessment was taking place the government was preparing a comprehensive report on the safeguarding of children living away from home.²⁷ Hackney had recently experienced concerns about abuse in its own children’s

²⁵ For example Andrew Kendrick, *Who Do we Trust?: The Abuse of Children Living Away from Home in the United Kingdom*, Paper presented to the 12th International Congress on Child Abuse and Neglect; Protecting Children: Innovation and Inspiration, ISPCAN - International Society for Prevention of Child Abuse and Neglect, Auckland, 6-9 September 1998

²⁶ Warner, N. (1992). *Choosing with Care: The Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes*. London: HMSO

²⁷ Utting, W. (1997). *People Like Us: The Report on the Review of Safeguards for Children Living Away from Home*. London: The Stationery Office

- homes, as had a neighbouring borough. The recruitment of the foster carers shows no evidence of the heightened focus on safeguarding that was a major contemporary concern.
- 6.22. Professionals who worked in the local authority at the time told the Serious Case Review about some of the practical considerations that shaped the approach taken. At the time Hackney was particularly keen to recruit foster carers because of concerns about the quality of care that was being offered by many existing carers and their lack of flexibility and sensitivity to the needs of children. A service manager who joined the local authority shortly after the foster carers were approved told the Serious Case Review that at that time in his view as many as 60% of the existing foster carers *'were not of a good standard'*. Another former manager described how many of the existing foster carers, who had often been fostering for a long time, would be inflexible and insufficiently child focused. Examples given were that they would not introduce themselves to schools when taking on the care of a child for the first time or would never be prepared to take foster children with them on their own family holidays.
- 6.23. At the time Hackney also wanted to reduce reliance on what were perceived as being expensive placements provided by a growing number of independent and private fostering organisations. The growth of a private market in fostering made local authorities less willing to let neighbouring authorities make placements with carers that they had recruited than had previously been the case.
- 6.24. The management review provided by Hackney Council for the Serious Case Review identified how prevailing professional attitudes shaped practice. Fostering assessments were marked by *'a reluctance to ask searching and challenging questions for fear of being perceived as judgemental'*. This resulted in *'important questions that may have been perceived as judging of lifestyle choices, class or personality not being asked'*. Whilst there were obvious concerns about aspects of the family history (such as the couple's extra-marital relationships) the social worker who carried out the assessment told the Serious Case Review that *'you worked hard not to make prejudicial judgements. You had to think ... "is this my own expectation or a genuine concern?"'*²⁸
- 6.25. As a result aspects of the foster carers' histories that deserved much closer scrutiny were not evaluated. Some came to be seen as positives. Weight was placed on the fact that the couple were at least being 'open' about their extra-marital relationships, whereas other applicants might not have been. The Hackney Council management review notes that this attitude applied in the fostering assessment but it was also evident *'throughout much of the involvement with the family'*.
- 6.26. Very pertinent concerns that were raised by the fostering panel did not lead to further detailed enquiries but were answered in the meeting by providing a positive re-iteration of information that was already known to the fostering team. The assessing social worker was honest enough to tell the Serious Case Review that he had 'liked' the couple and it is clear that he thought that they should be approved. The male foster carer told the Serious Case Review that his perception was that the assessing social worker had 'fought' for them to be approved. Section 6.38 considers further the potential for confusion to arise in boundaries and roles between foster carers and the fostering service.
- 6.27. Time pressures may have also influenced the outcome of the assessment. At the time members of the fostering service had to balance three roles: supporting and supervising

²⁸ There is a parallel in the local authority inquiry into the abuse of children by foster carers in Wakefield where staff found it difficult to voice concerns about gay foster carers.
<http://www.theguardian.com/society/2007/sep/12/guardiansocietysupplement.childreancesservices>

existing foster carers; providing a duty service to deal with new referrals, and recruiting and assessing new applicants. It is clear that the approach to fostering assessment lacked any focus on the potential vulnerability of children to abuse – even though this was the subject of much professional discussion at the time. This may have been a reflection of the fact that the fostering team had a number of unqualified social workers who had been transferred from roles as residential workers in children’s homes as part of a redeployment programme. The social worker who undertook the assessment obtained his professional qualification, via a part time secondment, two years later.

- 6.28. Less experienced and unqualified workers would necessarily have had less knowledge about wider discussions about the vulnerability of looked after children and (on average) less confidence to probe difficult and potentially embarrassing areas. It is clear in hindsight that to have transferred unqualified residential workers into qualified roles in the local authority fieldwork service led to a dilution of skills in the service as a whole and was a mistake. Such a strategy would now not be permitted by the regulatory framework.

Recent evidence of effectiveness

- 6.29. The Serious Case Review has considered two reports which offer evidence about the more recent quality of the recruitment and assessment of foster carers and the effectiveness of the fostering panel.
- 6.30. The last detailed independent regulatory inspection of Hackney’s fostering service took place in 2010. It gave a very positive account finding that *‘managers, staff and carers are demonstrably safe and suitable to work with children and young people. Recruitment practices are comprehensive and thorough. Staff and carers are clear about their respective roles and responsibilities with regard to safeguarding. This results in good safety outcomes for children’.*²⁹
- 6.31. It also judged that the fostering panel *‘serves children well and can demonstrate good outcomes. It is well managed with effective members who understand the needs of children. The panel chair confirmed that panel members receive sound preparation and training. The training includes child protection awareness and up to date knowledge about best practice in assessment and placement planning. The panel considers matches, exemptions and extensions to placements, the initial foster carer’s approval and first annual review. Where required, the panel also considers issues identified during the assessment and review process.’*
- 6.32. Following the allegations of sexual abuse made in 2012 Hackney Council commissioned a review of aspects of its current fostering arrangements from an independent consultant. The Serious Case Review has had access to the final report of the review and discussed its findings with the author.
- 6.33. The independent review highlighted a number of weaknesses in the existing arrangements for recruitment and assessment of foster carers and in the role of the fostering panel. It recognised that the local authority’s fostering recruitment procedures were updated in 2012 and that they provide practitioners with procedures and guidance about quality standards. Policies and procedures reflected proper current thinking about the approach that should be taken to information gathered from applicants’ children (including adult children), former partners, employers and past employers. They also point to the need for assessments to obtain evidence from schools and other statutory agencies (such as Child and Adolescent Mental Health Services) that are involved with the

²⁹ OFSTED, Inspection report for Local Authority Fostering Agency - London Borough of Hackney Fostering Team. Inspection date 20/09/2010

family. However the review noted that *'such checks are not routinely completed in all cases'* and that as a result *'vital safeguarding information could be overlooked'*.

- 6.34. On the two occasions when she had chosen to observe the work of the fostering panel the reviewer found that it had struggled to achieve the legally required membership. There were inconsistencies in attendance and in the manner in which the panel considered cases. The review highlighted concerns about the fact that a number of foster carers' annual reviews had not been taken for consideration by the panel, placing the local authority in breach of the fostering regulations.³⁰
- 6.35. In addition the review identified a number of assessments of connected carers (members of the child's extended family or network) with whom children had been placed which were *'significantly out of regulatory timescale'*. This was taken as evidence that in some instances the panel was not challenging the local authority with sufficient rigour and that as a result *'the fostering service was not being held to account for the delays'*.
- 6.36. A number of children's placements with 'connected persons' had been presented to the fostering panel with a request for extension of temporary approval which (according to the reviewer) the panel had no remit to grant. Other placements had not been presented to the fostering panel because the social work units responsible for the cases believed that the fostering panel would not consider placements to be suitable. The review highlighted this as a significant concern because it showed that the local authority was managing risk with insufficient senior scrutiny and outside the proper regulatory framework. The review noted that the local authority had responded positively to the findings by immediately commissioning an audit to establish the number of cases where fostering assessments that had not been completed in the correct way or within the regulatory timescales.
- 6.37. The independent fostering review made recommendations which the local authority has been implementing since mid-2013. The Serious Case Review recommends that the City and Hackney Safeguarding Board monitor the actions taken to implement the findings of the independent review of fostering services.

Professional relationships with the foster carers

- 6.38. The Serious Case Review has considered three aspects of the relationship between the foster carers and the local authority fostering service:
- How the carers came to be held in such high regard by the majority of staff in the fostering service
 - Why concerns identified by other staff were not addressed
 - How the foster carers conditioned the professional network.

Development of an overly positive view of the foster carers

- 6.39. Between 1997 and late 1998 the local authority placed thirteen children with the foster carers. One infant lived with the family for 18 months while the other children were all placed for brief emergency or respite care placements. Almost immediately Hackney's fostering service formed a positive view of the foster carers, based largely on the views of the allocated social workers for children placed with the family.
- 6.40. One feedback form completed five months after the foster carer's approval noted that they were cooperative, helpful and flexible and that the placement had had a good impact on the fostered children. The foster carers had worked well with the children's own families. Social workers who spoke to the Serious Case Review gave examples of insights

³⁰ The foster carer's first annual review should always be considered at the agency's fostering panel

- that the foster carers offered into aspects of the children's needs. Their home was sometimes noted to be 'chaotic' but this was offset by the fact that it was 'warm and welcoming'. The male foster carer's practice of taking photographs and making videos to provide children with mementos of stays was seen as particularly positive.
- 6.41. Almost all of the fostered children were too young to give their own views, but there had been no major concerns about the care of any of them. At one point the female foster carer admitted being 'out of her depth' when working with a very challenging parent. Minor conflicts and difficulties with birth parents and professionals were attributed to a lack of experience and viewed as expected teething problems. There was no further review or discussion of any of the issues about the foster carer's history and relationship that had been raised in the foster panel discussions. Supervision of the foster carers became largely focused on practical matters.
- 6.42. The foster carers participated in several training programmes, most notably three family members attended a course in British Sign Language to assist in meeting the needs of a deaf child. Scrutiny of the carers' suitability focused on the impact of fostering on their own children, because in the mind of the supervising social worker that had been the main concern arising from the assessment. Their views were recorded and their comments (such as a child saying that he would hide his best toys before a foster child arrived) understandably triggered no concerns.
- 6.43. At the first annual foster carer review the male foster carer commented that fostering '*evoked a range of emotions*' but there was no further discussion of this. The review changed the terms of the fostering approval to allow the carers to foster two children under the age of 10, though this was immediately exceeded as a group of three siblings was placed. Section 6.94 deals in detail with the number of children placed with the family.
- 6.44. Despite a number of concerns and some documented tensions the positive view held by the fostering service developed over the next eight years. The local authority management review summarises the professional perception that they were seen as '*competent, child focused, innovative carers, able to accommodate large numbers of children in their home*'. Over time the foster carers came to be seen as experienced and authoritative.
- 6.45. At their annual review in 2005 there was discussion about the sexualised behaviour of one of the children, the female foster carer is treated as an expert on the problem, it being noted that '*sexuality has been a concern for (her) and has been at the forefront in safe caring for the children*'. The review concluded that the foster carers have provided the children with '*stability and a secure base*' which has '*enhanced their overall development*'. In contrast these children were reported by their subsequent carers to be severely delayed and showing signs of having been under-stimulated and possibly neglected while in the foster home.
- 6.46. By 2007 her credibility was such that the female foster carer was given a substantial say in the choice of permanent carers for a child placed with them by shortlisting and visiting prospective carers. Whilst some consultation with a current carer would be expected and helpful, her role went well beyond normal expectations. By that point the impression created is of an established foster carer coaching inexperienced social workers.
- 6.47. The carers chosen for this child told the Serious Case Review that before visiting the family they were briefed that the foster carers would seek to dictate the arrangements for introductions and placement and would try to disrupt any arrangements that did not suit them. Their account is that social workers treated this as something that had to be

tolerated, not because it would be addressed or dealt with at a later point, but because this was simply how the foster carers were and it was 'a price worth paying' for the otherwise very good care that they provided.

Concerns voiced by neighbours

- 6.48. Former neighbours of the foster carers told the Serious Case Review that they had concerns about the first sibling group placed with the family, which they expressed to the children's allocated social worker during a chance meeting in the street. The neighbours state that they complained that the children were shabbily dressed and frequently had head lice. According to the neighbours the social worker played down the concerns about the children's physical care. The neighbours' account is that from this point they had other concerns about the children but took it upon themselves to offer practical assistance.³¹

Concerns about the accommodation and sleeping arrangements

- 6.49. From July 2003 a new supervising social worker (SSW4) took over responsibility for oversight of the foster carers. When she became involved a sibling group of three children (all under 8) were in placement and she was immediately concerned about the size and standard of their bedroom. For just over six months all three children had been sleeping in a small space subdivided from a larger room. Several descriptions confirm that it was no larger than 2.5 meters x 2 meters. Because of the way the larger room had been partitioned it had no window. A male child of the foster family (who was five years older than the eldest foster child) slept in the other part of the room which could only be accessed through the area where the foster children slept.
- 6.50. SSW4 told that Serious Case Review that although it was recognised that the accommodation was inadequate the fostering service had decided to tolerate this in order to keep the children together until a permanent placement could be found. This took a further two years. These arrangements offered no privacy and one of the fostered children is known to have been abused by two family members during this period. In late 2004 after complaints from the allocated social worker the youngest child was moved out of the partitioned area and into the space occupied by the child of the foster family (who was 8 years his senior) to separate the children along gender lines.
- 6.51. Records show that two other (younger) siblings from this family and a child who had a series of respite placements also stayed in the household during this period. It is not clear how these children were accommodated. SSW4 stated that according to her understanding of the fostering regulations the number of children placed at these points exceeded the maximum for a foster home. In 2005 the foster carers made an enquiry about becoming a foster carer with their own local authority. This was halted at the first contact because it was established that the family home '*did not have a spare bedroom*'. The two local authorities were evidently operating according to entirely different standards.

Shaping the relationship with the supervising social worker

- 6.52. SSW4 told the Serious Case Review that from the beginning she found the foster carers difficult to work with as they played on her relative lack of knowledge and experience and made her feel inadequate. Between July and December 2003 she made monthly support and supervision visits. Records show the same pattern of concerns and interactions, documented each month, but without any progress in resolving them:

³¹ There is no note of this conversation in the local authority records so it is not possible to date it with certainty. The social worker concerned first became involved with the family in 2001.

- The foster children were not seen because at the foster carers' request visits were almost always made during the morning when the children were at school
- As a result she could not evaluate the standard of care being provided.
- All visits to the foster home were announced in advance
- The foster carers did not attend training – excuses included too much traffic; school holidays; too many commitments due to number of children; the training course selected was full
- Health and safety checks were outstanding - and were eventually undertaken in April 2004
- The family's support network was to be CRB checked. This was identified in August 2003 but the only police check for a non-family member on the records for this period was for an elderly man which was carried out in January 2004. This person's role in relation to the foster children is not clear.

This pattern of interaction between the supervising social worker and the foster carers continued, with some minor variation for the next eight years.

Concerns voiced by an allocated social worker

- 6.53. In January 2003 the sibling group of three children was allocated a new social worker. She gradually formed the view that the fostered children were being treated differently to the foster carers' own children (for example having poorer quality meals) and she began to be concerned about their presentation and demeanour. She noted in a report to a local authority panel that she was concerned that one of the children might have been sexually abused, though she did not suspect the foster carer.³² She made unannounced visits and visited at times when she would have expected the family to be eating or interacting together.
- 6.54. Once the social worker started to become curious and concerned about the care of the children the female foster carer made a series of complaints about her. These were informal, rather than through a complaints procedure. This meant that they were never investigated thoroughly or by anyone independent who could form an objective view.
- 6.55. The social worker's visits confirmed her suspicions about the emotional health and behaviour of the children. However there is no indication in the written records that the concerns were formally raised until April 2004 when the social worker completed a standard feedback form for the foster carers' annual review. The most likely reason for this is that throughout 2003 the main focus of the social worker's activity was the complicated care proceedings involving all of the children in this large family. The process included contested hearings about contact, a residential assessment and the children's future legal status and placement. There was a complicating international dimension to the case. Section 6.99 draws together learning from the Serious Case Review about the extent to which social workers whose attention was focused on statutory and administrative aspects of cases were less able to build or maintain direct working relationships with children.
- 6.56. The social worker's written contribution to the April 2004 annual fostering review identified a number of concerns about the children and the female foster carer (while making no reference at all to the male foster carer). These include:
- There being no evidence of support for the children's education at home
 - The children's meals observed to be of poor quality
 - Concern that the foster carer would give a negative impression of professionals to the children

³² This episode is discussed separately in Section 4.

- The small size and cluttered state of the children's bedroom and lack of clean linen
 - Closeness of the children to the female foster carer (described as if it were an anxious pattern of attachment)
 - The female foster carer's unwillingness to compromise and negotiate
- 6.57. There are considerable difficulties with this report. One section has a tone which is entirely out of place in a professional document as it concludes by saying that the children *'are never relaxed. What is this saying? Make your own conclusion'*. The section on participation in looked after reviews notes that the foster carer *'attends the meetings but always with an attitude'* but gives no further information. The report finishes by asserting that the female foster carer *'cannot be trusted'* but gives no evidence. Some of the document is barely legible.
- 6.58. For reasons that the Serious Case Review has not been able to establish this report was dated two days after the foster carers' annual review was carried out and not sent to the fostering service in time to be discussed at the meeting. It did become part of the service record as it was referred to some months later. There is no evidence that the worker discussed the document or her wider concerns with her own supervisor. If she did there is no evidence of the supervisor taking action. She left the local authority soon after writing this report.
- 6.59. In contrast to the extremely serious concerns expressed in the social worker's report, the written record of the same annual review simply noted that the foster carers *'could be more flexible around visits'* and that the house was *'occasionally untidy'*. It noted that the foster carers had *'attended some training, but could attend more'*. It noted that the female foster carer *was a child minder for up to 4 children / day prior to fostering*. The implication appears to be that the foster carer could cope with so many children being placed in the house because she was used to it. It identifies difficulties with the behaviour and poor information sharing of the allocated social worker. It noted that there had been *'various placements'* over the approval limit but that exemptions had been made for them. It recommended continued approval for three children aged 0-12.
- 6.60. A month after the review an internal supervision note of the contact between SSW4 and the family recorded that there was *'nothing to note'*.
- 6.61. In October 2004 SSW4 and the fostering team manager discussed the recent report and the concerns identified in the social worker's March 2004 feedback form. Their focus was on the lack of space along with accusations that the foster children were given different food. It was agreed that an unannounced visit would be made at a time when the children could be seen. According to the written records this was the first unannounced visit to the home by the fostering service since SSW4 had taken responsibility for the foster carers (16 months earlier). The only previous written reference to an unannounced visit from the fostering team was in 1998 (though there may have been others that were not recorded as such).

Continuing the accommodating pattern of supervision

- 6.62. After the annual review in 2004 the supervisory visits to the foster home reverted to the pattern identified the previous year. The foster carers continued to fail to attend the fostering support group or training programmes. In later 2004 the female carer did attend a course titled *'Working with the Department'*, which she told SSW4 she found *'interesting'*.
- 6.63. In August 2004 the social worker allocated to search for a permanent family for the three children visited the foster family to meet the children. After the visit a letter was written

- wrote to SSW4 setting out similar concerns about the standards of care and cleanliness in the home. It is significant that professionals visiting the house for the first time raised concerns, whereas those who had been in contact with the family for some time had ceased to treat the difficulties with any sense of urgency.
- 6.64. During 2004 and 2005 there was very little recorded evidence of contact between allocated social workers and the foster family. There were a number of changes of social worker in this period and concerns – recognised within the local authority at the time – about the quality of social work provision.
- 6.65. The chronology for the period mid 2004 – late 2005 provided by the local authority lists the following contacts:
- two social work visits to the children, and possibly some other meetings that took place at the foster home at which the children may have been seen
 - five visits by SSW4 to the family, although there is no record that the children were seen on these visits
 - an annual foster care review and
 - a looked after child review (which was held on schedule in mid-2005).
- 6.66. Notes of these contacts show the female foster carer steering discussion into areas where she could present a positive view of the work that she had undertaken with the children over the course of their placement.
- 6.67. During 2004 it had been decided that once the sibling group placement ended the fostering approval would be reduced so as to allow the family to foster only two children. Although the placement ended at the end of 2005 the approval was only changed in February or March 2007. The delay appears to have been due to the open hostility of the foster mother to this.
- 6.68. There is no evidence that the fostering service was able to address any of the continuing concerns about the foster carer's attitude and behaviour towards professionals. Nothing substantial changed in the pattern of supervisory visits or interaction with the foster carers. For example when she made an unannounced visit in June 2005 it was at a time when the children were at school and so not likely to have identified anything of significance.
- 6.69. The children left the placement at the end of 2005. Further concerns were noted about the foster carers' behaviour at the last family contact and in failing to pass over information and possessions to the children's new carers.
- 6.70. From 2006 onwards there were far fewer placements in the foster home and fewer concerns about the quality of the care provided. The foster mother's attitude to and behaviour towards social workers did not change and came to be accepted. SSW4 found it increasingly difficult to arrange visits and reviews and the foster carers again attended no training without any action being taken.
- 6.71. In 2008 the female foster carer ceased most of her contact with the local authority (although she remained an approved carer) and from that point on the male foster carer attended meetings with social workers and some training sessions.
- How the foster carers manipulated the professional network
- 6.72. It is important to understand these events as part of a strategy on the part of the foster carers to undermine the capacity of the professional network to discover what was happening to the children in their care. Those who seek to abuse children need to condition or groom the professionals who are working with children as well as the victims.

- 6.73. Erooga has recently reported research into a range of what are termed ‘manipulation styles’.³³ This describes the ways in which perpetrators who were working in a professional role with children sought to create a positive impression among some co-workers, in order to draw them closer, or to undermine the credibility of those who might have suspicions or might be able to act in a protective role. They included:
- Being overtly altruistic and thoughtful about the needs of children
 - Stressing their own ‘integrity’ and expertise
 - Aggressive, intimidating or insidious controlling behaviour (which may be shown towards both child victims and other professionals)
 - A pretence of being ‘put upon’ suffering either in their own past or in their present role by taking on extra work or duties
 - Presenting themselves as ‘broad minded’ or liberal in attitude
 - Obstructing or blocking approaches and withdrawing from contact with colleagues altogether (for example by avoiding training and supervision).
- 6.74. The intention is to make it appear acceptable for the perpetrator to act outside of normal professional boundaries, either by being a very good worker or a very difficult or powerful one. Behaviour fitting all of these categories has been described at various points in the preceding paragraphs. It presented a significant challenge to the professional network. The following paragraphs explain why Hackney’s fostering service was unable to respond effectively.
- 6.75. Positive perceptions of the carers formed during the fostering assessment in 1996-97 and were strengthened as a result of the success of the placements made in 1997-98. As a result doubts about the foster carers’ histories, behaviour and motivation which had been raised in the fostering assessment were never revisited, although these were significant ‘static’ risk factors that could have remained very relevant. For example the male foster carer had been in care; the female foster carer had had extramarital relationships; they did operate in very separate and defined roles. These difficulties should not have been seen as being entirely offset by reports about their positive current work as foster carers.
- The nature of fostering services
- 6.76. Features of fostering services make it more difficult to recognise poor practice or care. Foster carers work at some distance from the organisation and their close interactions with children are not easy to monitor. They often require considerable emotional support in caring for very difficult children. The local authority management review identified ‘*an organisational culture within which individual supervising social workers felt pride when “their” foster carers did well*’. The reverse of this may be a natural defensiveness when foster carers are criticised. This is a perfectly understandable human bias. One former member of staff with substantial expertise in adoption services told the Serious Case Review that this remains a strong and potentially concerning feature of the team in which she currently works (which is in another local authority).
- 6.77. The fostering service was unable to respond effectively to concerns about poor care because key staff (and perhaps the majority of staff) held a fixed positive view about the foster carers which was not altered in the face of evidence to the contrary. The majority of members of the service held on to the belief that the foster carers were providing a good service despite the fact that much of the objective information held about the foster carers was at odds with this view. The continuing involvement of key members of staff in the fostering service made it more likely that the positive view would persist. Most importantly the social worker who assessed the foster carers became their first SSW and

³³ Erooga (op cit) pages 90-97

later a team manager. This limited the scope for more junior members of staff to challenge established views of the carers.

The impact of human biases and 'groupthink'

- 6.78. New evidence that challenges an established viewpoint often has less impact than it should because people are unwilling to let go of established beliefs. Munro calls this '*the single most pervasive bias in human reasoning*'³⁴ listing 'avoidance', 'forgetting the evidence', 'rejecting the evidence' and 'reinterpreting' as reasons why it happens.³⁵ All of these factors applied in this case.
- 6.79. At times the local authority missed opportunities to gather information (for example by SSW4 visiting for many months at a time when the children would not be seen and then social workers not visiting at the frequency required). Potentially negative information was reinterpreted positively. For example it was viewed as understandable that the household was chaotic and disorganised because there were so many foster children living there and the foster carers were said to be used to it anyway. On a number of occasions information was ignored or acted on slowly because it came from professionals whose opinions were not highly valued.
- 6.80. The most concerning episodes concern evidence that was ignored altogether, even though it was objective and hardly open to alternative interpretation. The evidence of overcrowding very obviously led to the children having a lack of privacy and made them more vulnerable.³⁶
- 6.81. The fostering service placed more weight on the foster carer's complaints about one of the children's allocated social workers than on her concerns about the care of the children. There is no doubt that personal factors played a part. Although this social worker was appreciated by some colleagues as being very child focused, others have described her as anxious and disorganised. The fact that she had so many serious concerns but failed to provide feedback on the foster placement in time for the annual review meeting supports this, as does the actual state of the feedback form described in 6.53 above. It raised very serious concerns but was not of a proper professional standard. Her credibility was further undermined by the foster carers' repeated complaints. She in turn had no faith in what she termed 'management' and there is no written confirmation that she ever raised her concerns with her own manager.
- 6.82. The danger that a collective opinion (often referred to as 'groupthink') may develop in a team, group or service has been recognised in writing on safeguarding for over two decades. Factors that can lead to unhealthy group reasoning and mechanisms designed to reduce the risk of it happening are well documented.³⁷ In work that relies on the development of strong, trusting relationships to deal with very challenging tasks '*it is easy to identify the ways in which reasoning is faulty. It is not so easy to provide an answer*'.³⁸
- 6.83. The foster carers' treatment of SSW4 – who was the supervising social worker for the family for eight years - was critical. From the beginning the foster carers established the 'ground rules' for their relationship. They did this by dictating when and how meetings would take place; then by noting her concerns and requests but ignoring them. Her ability

³⁴ Eileen Munro, *Effective Child Protection* (2nd edition) page 137

³⁵ *ibid* page 138

³⁶ There is corroborative evidence to indicate that Hackney struggled with the issue of overcrowded foster homes at this time. The 2004 OFSTED inspection of fostering services noted that in its sample there were two serious examples of children in foster homes where there were serious concerns about the accommodation. It concluded that '*while inspectors appreciate the general difficulties presented with regard to housing, these were matters of significant concern*'.

³⁷ Munro (*op cit* pages 148 – 151) cites research by Janis (1982) suggesting six '*measures to promote against groupthink*' which remain entirely relevant

³⁸ Munro (*op cit* page 139)

to persuade the family to improve was further undermined by the fact that her colleagues held the carers in high regard and the member of the team who had undertaken the original fostering assessment (who liked the family and got on well with the foster carers) was now her team manager. When she voiced concerns with colleagues she received little support and concerns about standards of care were minimised.

- 6.84. The local authority management review established that *'she was aware that (the female foster carer) was making comments about her to other social workers and to management that she viewed as undermining which may have led to a reduction in her confidence in herself and children's social workers' confidence in her'*.
- 6.85. As a result she *'believed herself to be responsible for the relationship difficulties'* and felt that it was her responsibility to work them out. The local authority review has noted that, *'questions were not raised by managers or SSW4 to further consider these dynamics and what purpose they may be serving.... At no time did it appear the questions were asked about whether (the female foster carer) was intentionally pushing the SSW away or purposefully discrediting her'*.
- 6.86. This left SSW4 with limited confidence and no ability to challenge the carers. It was also part of a pattern of behaviour that led children and others to have less confidence in social workers.

Individual professional practice and organisational culture

- 6.87. Both of the supervising social workers who spoke to the Serious Case Review recognised organisational and personal shortcomings in the provision that had been made. In relation to their personal practice both emphasised that the most significant change has been that they would now spend much more time in direct contact with foster children, if possible away from the foster home, in addition to and independently of the requirement that allocated social workers must visit children who are looked after.
- 6.88. However it is important not to view these as solely matters for individuals to address. Organisations must provide structures that encourage challenge and critical thinking. During the period under consideration Hackney's fostering service was organised along traditional lines, with a team of 8 or 9 social workers managed by one team manager. Periodic reorganisations had slightly altered team responsibilities. In 2010 – 2011 Hackney began the process of introducing its unit model of social care provision into the looked after children and fostering and adoption services.³⁹ As a result staff in the fostering service began to work in multi-disciplinary units of five staff on more specific aspects of fostering or adoption.
- 6.89. SSW4 was able to reflect on the difference that this might have made to the difficulties that she experienced in challenging the foster carers in the face of the established positive view of team members. The current structure would increase the likelihood that there could be joint visits to the family, visits undertaken by other members of the unit (since the unit holds the case rather than the individual worker) and more challenging discussion about the difficulties of working with the foster carers.
- 6.90. However she also pointed to the danger that when a social work unit lacks personnel in key roles it will be less resilient than a larger team. It is important to recognise that an unhealthy group consensus can emerge in a team of this size – in fact there is a case that groupthink can develop more easily in small teams and meetings if there is no dissenting voice. It is therefore vital that the unit leader explicitly encourages criticism of his or her

³⁹ S Goodman and I Trowler (eds) (2012) *Social Work Reclaimed*, Jessica Kingsley; London

own views, that the group is scrutinised from the outside and that it remains open to external monitoring and challenge.

- 6.91. The local authority has recognised the risks that arise from the nature of the relationships between foster carers and the fostering service:
'This review demonstrated confusion in boundaries, alliances, roles and responsibilities in the relationship between foster carers and social workers. In order to navigate these relationships, rigorous standards must be applied with an expectation of constant challenge and scrutiny of the relationships between social workers and foster carers to ensure that these do not become enmeshed or compromised.'
- 6.92. Two important pieces of learning emerge from this analysis. The more knowledgeable they are about the motivation of offenders to abuse and the nature of patterns of abusive behaviour, the better placed professionals who work with children will be to identify potential risks to children from professionals who are seeking to misuse their position of trust. Features of fostering services may make it more difficult for professionals to recognise risk. This needs to be considered carefully in their organisational arrangements and working practices.
- 6.93. The local authority has identified a series of actions that need to be taken and made recommendations in relation to this. These are endorsed by the Serious Case Review, which will ask the LSCB to monitor the outcomes achieved and challenge the local authority should that be necessary.

Fostering approval, annual review and other mechanisms designed to make foster care safer

- 6.94. Fostering regulations contain checks and balances designed to make foster care as safe as possible. This section of the report comments on the way in which these were interpreted and implemented in Hackney during the period under review. The functions of the fostering panel (and particularly its role in relation to approval of foster carers) are dealt with in Section 6.14.

Compliance with fostering placement approval categories and placement of children exceeding the normal limit for a foster home

The overall fostering limit

- 6.95. Fostering regulations set a usual fostering limit for the number of fostered children who may live with approved foster carers.⁴⁰ The usual limit is three, though an exemption may be granted by the local authority.⁴¹ On a number of occasions the placement of a combination of sibling groups and other fostered children meant that the number of looked after children in the foster carers' home exceeded the overall fostering limit. A number of exemptions were granted retrospectively, often after a considerable delay. These are discussed in more detail below.

Fostering approval

- 6.96. Within the overall limit fostering agencies approve foster carers to look after a number of children through the agency's fostering panel and its other procedures. Fostering agency approvals set out the age, gender, specific needs of the children and the type of placement being provided (such as emergency, respite care, permanent). The terms of the approval will be based on the agency's judgement about the skills, abilities and

⁴⁰ Except where the children are all siblings, a person may not foster more than three children unless he/she is exempted from the 'usual fostering limit' by the local authority

⁴¹ A larger sibling group may be automatically exempted. That was not relevant in this case

circumstances of the foster carers and what they want to offer. Details of the approvals that applied to the foster carers in this case are set out below.

- 6.97. Placements may be made outside of the approval according to the arrangements made by the individual fostering agency. In Hackney during the period under review exemptions from normal approval were granted by a service manager.

The total number of children in the household

- 6.98. There is no specific limit on the total number of children (including children of the foster carers) who may live in the household of approved foster carers at any time. The fostering service should always know who is living in the household. This should be considered as part of the initial fostering assessment and approval and during the foster carers' annual reviews.

- 6.99. When foster carers have older children by birth or stepchildren the fostering service should know whether they are living in the household or not. In this case it has not been possible to establish from the records whether Hackney's fostering service always knew this. It was established at the time of the fostering approval. However with the passage of time there is no evidence to show that it was monitored.

- 6.100. Based on the records provided by Hackney and using the best estimates of when their own children left home, the Serious Case Review believes that the number of children in the foster carers' household usually varied between seven (in 1998) and five (in 2007-8). This included the foster carers' own children, long term foster children and children having respite stays. For a period of about a month in mid-2001 the evidence is that there were nine children and young people living in the household including one infant, four primary school aged children, two young adolescents, and two older teenagers. There may also have been other children placed by Hackney's emergency duty team for very short stays.

Exemptions and changes of approval granted in relation to the foster carers in this case

- 6.101. In early 1996 the foster carers were approved to provide care for one child of either sex aged 0-5. This was increased in late 1997 to include a child aged 5-12 for respite stays because the family had coped well with initial placements and this would allow them to care for older children. In 1998 it was increased to one child (age 0-5) plus two children (age 0-12) for respite stays.

- 6.102. In late 1998 a sibling group of three children was placed with the family, requiring an exemption to the normal approval. It is assumed that the exemption was initially agreed by the service manager although the relevant records have not been found so it is not possible to confirm this. The reasons for this are set out below.

- 6.103. As far as the children's allocated social worker and her manager were concerned this placement was needed very urgently. It met their immediate requirements because it allowed the children to continue to attend their existing school and met the stipulation of the court for a placement that would allow regular contact with other family members. Given the complexities of the case no one could blame them for accepting the placement and they would probably not have understood the technicalities of the fostering approval regime.

- 6.104. The first record of a formal discussion about the need for an exemption was at the foster carers' annual review in February 2000 (15 months after their placement). Subsequent records show that the exemption was approved by the fostering panel in April 2000. It is not clear at that point whether the fostering panel was told that it was the intention of

- the fostering service to continue to make other respite and short-term placements which would inevitably lead to the number of children exceeding the usual fostering limit.
- 6.105. The placement approval was next altered in 2007, following the concerns that had been raised during the placement of a second set of siblings in 2004-2005. Section 4 above has described this in more detail.

The system for granting exemptions

- 6.106. Hackney's management review was not able to establish in detail how the exemptions were made. A former manager told the Serious Case Review that '*exemption forms were kept in a folder and not placed on the children or young person's file*'. The local authority has tried, unsuccessfully to find this information which appears to have been lost or destroyed when the service moved location. It is therefore not possible to be certain whether the initial exemption decisions were taken in line with the local authority's procedures or how they took into account the needs of the children.
- 6.107. The management review was able to establish the broad approach that was taken to placements which fell outside the existing approval. It confirms that '*in the late 1990s / early 2000s, variations in terms of approval were made by managers and potentially considered at the next annual review or fostering panel*'. It was established from interviews with staff who had worked in Hackney between 1998 and 2005 that '*placing a child outside the approval category was not seen as problematic*'.
- 6.108. Interviews with staff and managers also established differences in understanding about how the regulations in relation to the overall fostering limit should be interpreted. One member of staff reported that it had been acceptable to treat a sibling group of three as 'one placement' rather than three children. Others were aware that if there were more than three fostered children in a placement it would mean that the placement would cease to be a foster home and its regulation would then '*go into the realms of*' a children's home.
- 6.109. The service manager believed that this was a correct position in principle but he also felt that there was sometimes a pragmatic need to adopt a more permissive reading of the regulations. His reasons were significant. Firstly they related to the financial circumstances of the council which he stated resulted in '*massive pressure to use in-house foster carers and not agencies*' (independent fostering providers). Secondly he took the view that it was acceptable in some instances to interpret the regulations in a flexible way and '*use some fostering placements creatively*' because there were some good foster carers who '*could cope*'. As they had a vested interest in down-playing the needs and difficulties of the children that they were looking after, the foster carers who are the subject of the review always went to great lengths to present themselves as carers who could 'cope'.
- 6.110. There is evidence that this interpretation of the fostering regulations over the status of sibling groups was not unique to Hackney. A number of former members of staff who now work for other fostering agencies told the Serious Case Review that it remains 'ambiguous' in other organisations.
- 6.111. Overall it is clear that between 1998 and 2005 Hackney's fostering service had insufficient oversight of the number of children living in the foster home. At times pragmatic decisions were made to allow the foster carers to look after more children than their practical circumstances allowed. At times managers took decisions that were outside both the spirit and the letter of the fostering regulations. As there were delays in seeking ratification of these arrangements through the fostering panel this risk was managed outside of the fostering regulations and without the degree of independent scrutiny

which the panel is designed to provide. In combination with the inadequate accommodation, the large number of children placed in the foster home diminished the quality of the care that they received and made children more vulnerable.

Foster carers' training and professional development

- 6.112. The foster carers participated enthusiastically in training and group discussions during their assessment and in the 12 months following their approval. After that they repeatedly failed to take up training opportunities and the local authority failed to address this. In 2007 the fostering service introduced a revised approach to training and support which required foster carers to complete a portfolio to illustrate their training and competence. There is no evidence that they began work on it.⁴² It is not clear whether the foster carers failed to attend training because they deliberately wished to avoid contact with trainers and other foster carers or because they were simply indifferent to anything that they might have learnt.
- 6.113. It is not suggested that anything the foster carers might have learned on training courses would have curbed their abusive behaviour. It is a matter of speculation as to whether attendance might have highlighted any concerns. It would have provided a setting in which trainers, other members of the fostering service and other foster carers would have learnt more about their attitudes and behaviour, to the extent that they presented them honestly. However it is clear that they would have been extremely adept in using the range of 'manipulative styles' described previously to paint a positive picture of their practice and deflect any concerns.
- 6.114. The more fundamental issue is the fact that there was never any concerted attempt to enforce the requirement to engage in training. The conduct of professionals who work with children who repeatedly operate outside of the norms expected of their team or service is a clear indicator of risk and should always be viewed as potentially concerning. Refusal to attend training was only one example of the way in which the foster carers did this.

Safeguarding training for staff in the fostering service

- 6.115. A number of members of staff and former members of staff in the fostering service were interviewed. The majority stated that they had attended some training on safeguarding, usually in relation to safe recruitment and the management of allegations through the Local Authority Designated Officer. The interviews left the impression that none had an in depth knowledge of safeguarding or any specialist knowledge of the dynamics of abusive behaviour as it might apply to fostering and adoption or child sexual abuse. The local authority has made recommendations which are designed to address this.
- 6.116. With a small number of exceptions staff in the fostering service and looked after children service (especially those in specialist or therapeutic roles) gave the impression that they saw safeguarding responsibilities in procedural terms (i.e. if there was an incident there should be a referral and there might be an investigation which someone else would be doing). Interviews gave little sense that staff could integrate knowledge of safeguarding and thinking about children's needs. Understanding of the potential vulnerability of looked after children to further abuse was present, but very general.
- 6.117. In future staff knowledge and training needs to be driven by an understanding of the vulnerability of children in public care and a clear sense that everyone in the service has to understand their role in safeguarding and has to adopt an active stance.

⁴² Existing foster carers were given three years to complete the portfolio

Annual foster carer reviews

- 6.118. Foster carer annual reviews were required by the fostering regulations throughout the period under review. Regulations state that the first review after initial approval should be considered at the agency fostering panel. Guidance on fostering services has always stressed the value of the input provided by looked after children, foster carers' own children and allocated social workers to these reviews.
- 6.119. The annual review held in mid-2004 provided a key opportunity to evaluate concerns about the quality of care being provided by the foster carers but this did not happen for the reasons described in detail previously (see Section 4).
- 6.120. The foster carers' reviews normally took place at the required intervals. However there was no annual review in 1999 (i.e. there was a 16 month gap between a review held at the end of 1998 and the beginning of 2000). There is no evidence that a review was held in 2009. No specific reasons are recorded but it is clear from the records that this was a time when relationships between the local authority and the foster carers were particularly poor and the foster carers were not cooperating with the supervising social worker. There is no evidence that this was identified in supervision or internal audit or that action was taken.
- 6.121. Prior to 2007 annual reviews were conducted and managed within the fostering service. In 2007 an independent reviewing officer (IRO) was appointed specifically to conduct the reviews in order to provide additional independence and scrutiny. This did not have a significant impact in this case, though that may be because this coincided with the point in time when there were fewer children placed and fewer concerns voiced about the quality of the care of the children.
- 6.122. The local authority has established that the last three years annual reviews were only attended by the male foster carer, although the foster carers continued to be approved as a couple. The IRO and the supervising social worker should have challenged that but appear not to have done so because the only young person living in the foster home seemed to be flourishing.
- 6.123. The carers who looked after all of the children after they left the home in which they were abused had concerns, some minor but some very substantial, about the care that had been provided. The annual review would have provided an ideal forum to air, evaluate and address these concerns.
- 6.124. The IRO who was responsible for the annual reviews after 2007 acknowledged that foster care reviews did not routinely collate 360 degree feedback about a foster carer, and rarely received completed self-evaluation documentation from foster carers themselves, feedback from social workers, looked after children or birth children of foster carers. This substantially limited their effectiveness.
- 6.125. Evidence from external inspection reports suggests that compliance with the requirement to conduct annual reviews improved during the period under review but it does not give any indication as to their quality or effectiveness.⁴³ Hackney's commissioned independent review (referred to in detail above) found that some first annual reviews had not been considered by the fostering panel as they should.

⁴³ In the 2004 OFSTED inspection of the fostering service it was noted that 'Approved foster carers are reviewed annually'. The 2006 inspection noted that 'foster carer's annual reviews were generally taking place on time and this had improved since the last inspection, however this could be improved further'. The 2010 inspection report simply notes that 'the approval of each fostering household is reviewed annually and reports are available to the Fostering Panel'.

- 6.126. In any fostering agency with a large number of carers there is a danger that annual reviews of foster carers will become routine. It is a very real challenge to make the process one that provides real insight into the quality of the care that is being provided for children and thus more likely to be more successful in identifying problems. The local authority is taking action to improve the quality of foster carer reviews and the Serious Case Review will recommend that the LSCB should monitor the outcome of the measures taken.

Annual file audit

- 6.127. The foster carers' records in the fostering service were subject to annual audit monitoring. This highlighted matters that needed to be addressed on a number of occasions (including for example recognising that unannounced visits to the foster home had not been made). However it did not identify the absence of an annual review in 2009. Overall there is no evidence that action was taken to follow up the auditors' comments and no evidence that supervisors subsequently chased up the actions recommended. As a result it had no effect.
- 6.128. It is not clear whether this was reflective of practice in relation to audit more widely or whether the specific difficulties that applied to the work with these foster carers were to blame. The local authority has made a recommendation in relation to this which the Serious Case Review endorses.

The role of social workers in seeing looked after children and listening to their voice

- 6.129. This section of the report evaluates the effectiveness of the work undertaken by social care staff in developing and maintaining relationships with looked after children, the steps taken to establish their wishes and feelings and the opportunities provided to make it possible for them to speak to someone about abuse. It also considers the effectiveness of looked after children's statutory review meetings.
- 6.130. As the Serious Case Review covers the work of the local authority spanning a period of ten years the evaluation is a summary of the main themes. The management review prepared by Hackney children's social care service contains a more detailed account of the evidence about direct work with children and their involvement in looked after children reviews that was documented in the children's records. An anonymised summary of this has been included as Appendix IV of this report.

The perspectives of young people

- 6.131. Three of the young people centrally involved spoke (separately) to members of the Serious Case Review team, as did their carers. The review team also spoke to the carers of four other children.
- 6.132. The three young people interviewed had very negative recollections about the social workers they had been involved with, spanning the episode when they were taken into care, the period when they were in the foster home and subsequently. They recalled having little direct contact with their social workers and they felt that there had been too many changes of social workers.
- 6.133. As younger children in care they had no specific recollection of being taken out of the foster home and seen alone by social workers, though all were of an age where it would have been right to do this.
- 6.134. Their perception was that social workers had often been unreliable over very basic matters such as timekeeping, sometimes did not keep appointments or cancelled them at very short notice. One young person described how social workers had not organised

- simple things properly because they had not appreciated the very high levels of anxiety that a looked after child might feel over something small and apparently insignificant. She recalled the panic that she had felt when a passport needed for a holiday – planned for many months – had not arrived. Her logic was that if she could not trust a professional over a simple thing like keeping an appointment it would be very difficult to trust the person to deal with the major problems in her life. There is no counter argument.
- 6.135. This finding echoes themes consistently identified in research conducted over more than two decades with children who are in contact with professionals because of child protection concerns.⁴⁴ Young people value professionals who do the simple things properly and do what they say that are going to do.
- 6.136. This is of greater importance because it is now apparent that part of the strategy adopted by the foster carers (in particular the female foster carer) was to ‘rubbish’ the children’s social workers by pointing out their errors and weaknesses. The tactic was a powerful one which made young people less likely to have confidence in their social workers (and professionals less likely to have confidence in one another). One long-term carer told the Serious Case Review that her daughter began to repeat the foster carer’s often-repeated view that social workers were ‘no use’ and that she had to make a conscious effort to counter it.
- 6.137. It is important to be realistic about whether any of the young people involved are likely to have talked to a social worker about abuse during a visit. Given the nature of child sexual abuse and the difficulty that many victims have in discussing what has happened it would be rare for a child to disclose the details of abuse to a social worker, even if the social worker was visiting the child at more than the six weekly minimum. Young people usually disclose abuse to those that they see often, know well and have grown to trust.
- 6.138. It may be unrealistic to expect looked after children to be able to talk to social workers about all of the most difficult issues in their lives, though of course there will be exceptions. It is however absolutely essential that the child should see the social worker as someone who is reliable, has a good knowledge of his or her past, knows the important people in the child’s life, observes the child carefully, asks thoughtful questions, listens to their views and explains things clearly. If a child has something very distressing to tell, they may well not choose to disclose it to the social worker but they need to have a strong sense that the social worker is part of a group of people around the child who can understand and deal effectively with troubling information. That would significantly increase the likelihood of the child choosing to tell someone.

Independent Reviewing Officer oversight of the children

- 6.139. Looked after reviews were held regularly for the children. However the specific concerns about the poor quality of some aspects of care provided by the foster carers (set out in section 6) the specific concerns about sexualised behaviour (section 4) and the lack of progress in planning for children were not addressed successfully at the review meetings. Given the large number of reviews held on a number of children over several years the reasons for this will have varied.
- 6.140. One of the most likely contributory factors is the very large number of independent reviewing officers (IROs) who were involved. For example five independent reviewing officers chaired looked after review meetings with the second sibling group between 2002 and 2006, making it extremely difficult to offer any continuity of oversight.

⁴⁴ For example Roger Barford (1993) *Children's Views of Child Protection Social Work*. Norwich: Social Work Monographs. (Social work monographs, no.120). NSPCC Library at QLJ JD, ISBN 1857840097

- 6.141. It is recognised that since the period under review the role of IROs has been changed through the issue of revised statutory guidance. As part of its monitoring of the safeguarding of looked after children the LSCB should ensure that IROs are making an effective contribution to the safeguarding of looked after children.

The role of partner agencies

- 6.142. Although the expected partner agencies such as schools, GPs and other services had been involved with the children, chronologies provided for the Serious Case Review showed that they had very little information that was relevant to its terms of reference. The only exception to this is Hackney's LAC health service which is considered specifically below.
- 6.143. With hindsight it seems likely that the foster carers employed a strategy of presenting themselves as being able to cope with the children's needs and thereby minimising their contact with other agencies. This was exacerbated by gaps in social work provision which made it less likely that referrals would be made to relevant support services such as child and adolescent mental health services. Most of the social work referrals to these services were made some time after the children left the foster carers.

The role of schools and other education services

- 6.144. It is very noticeable that schools and other education service records held very little information that was of significance. This is in part a feature of the pattern of interaction between the foster carers and the children's schools.
- 6.145. When they were living in the foster home all of the children went to local mainstream schools and attended very well. A number of the children had identified special educational needs which were viewed as being linked with their general developmental needs or their experience before coming into care.
- 6.146. At the time when the first sibling group was in the placement there were no procedures for coordinating the education of looked after children so (for example) there were no PEP meetings.⁴⁵ The records seen by the Serious Case Review give no indication of direct contact between the school and the local authority social care service. A neighbour of the family became very involved in the children's lives. She worked in their school and sometimes took the children to school. The school occasionally mentioned minor concerns to the neighbour assuming that they would be passed back to the foster carers; however the neighbour told the Serious Case Review that she often sorted things out for the children herself. There is no evidence that the school contributed to looked after reviews. The female foster carer always told their social workers that the children were making good progress at school.
- 6.147. There is also no evidence of direct contact between the school and the local authority in relation to the second sibling group. At two looked after review meetings there is mention of the need for the school to be contacted to produce a PEP, but there is no record that this happened before the children had moved to another placement.
- 6.148. It appears that if the schools had concerns about the children they would be relayed to the female foster carer, who would take no further action. There is no evidence of the foster carers relaying concerns expressed by schools to the allocated social workers. There are occasional discussions about the children's behaviour in school at LAC review meetings. These normally take the form of the female foster carer explaining her understanding of the children's needs and the work she had done to help the children address their problems.

⁴⁵ Personal Education Plan – required now to coordinated the educational provision for all looked after children

- 6.149. In 2004 the allocated social worker expressed concern in her feedback form for the annual foster carer review that the foster family were not offering very much support for the children's education. It is not clear exactly what this meant and no action was taken to follow up the remark.
- 6.150. After they left the foster home both groups of siblings received much better and consistent support with their education. There were PEP meetings and measures were put in place to seek to address the emotional and behavioural problems that affected the children's education. Some of the children received counselling support through their schools. There is no indication that any of the children ever sought to confide in school staff about the sexual abuse by the foster carer.
- 6.151. In relation to two of the children their schools identified concerns about sexualised behaviour or possible inappropriate sexual contacts between the foster children and other young people. The records show that these were appropriately managed by the schools and the local authorities concerned. The problems appear to have been seen more as behavioural concerns linked to abuse that had happened at some unspecified point in the past. The enquiries in to the welfare of the children concerned did not shed light on the specific circumstances of any past abuse.
- 6.152. For the children who lived in the foster home after 2007 the focus on educational needs was much more in keeping with current expectations of good practice. The children had specific plans to address their educational needs.
- 6.153. The provision described prior to 2006 is probably characteristic of provision during that period, prior to the full development of statutory guidance on the education of looked after children and the creation of the functions of a virtual head teacher.⁴⁶ The local authority now has entirely different expectations in relation to the education of looked after children and for the relationships between social care staff and schools and education services. Its virtual school would provide an independent source of information about the educational achievement and wider progress of children.

The role of the LAC health services

- 6.154. Every local authority is required to provide services to promote the health of looked after children. Hackney's LAC health team (LACHT) is commissioned jointly by the London Borough of Hackney and Hackney Clinical Commissioning Group. There has been considerable continuity in the commissioning and provision of services during the period under review. Like the account of educational services in the previous section the involvement of the LAC service reflects the very different expectations of the service at different points in time.
- 6.155. The LAC Health provider submitted an individual management review for the Serious Case Review which gives a detailed account of the contacts that the service had with the fostered children. The records show nothing which indicates that there were allegations of abuse or that potential signs and symptoms of sexual abuse were missed. Although proper documentation was made of all of the health assessments that were undertaken the formats used at the time of most of the assessments did not enable some important information to be captured. For example it is not always clear whether the children were seen alone and spoken to separately from the carers or social workers who accompanied them to appointments and it was not always clear whether information provided came

⁴⁶ The role of the Virtual Head Teacher is to coordinate educational interventions and support for looked after children in order to improve their educational performance

- from the child or the accompanying adult. Sometimes it was not clear who brought the child to the appointment.
- 6.156. For the first sibling group 13 of the 30 LAC health assessments that should have taken place were recorded as having happened. The figure for the period when they lived with the foster carers was 5 out of 12 assessments. There are several reasons for the low figures. During the period under review each individual health assessment was triggered by a referral from the allocated social worker and the commissioned health team had no separate method for scheduling and reviewing attendance at health assessments. At the time the health assessments of children who lived outside Hackney were undertaken by a clinician in the child's local area and arranged by the social worker and carer. This made the system less reliable. Copies of assessments should have been sent to the LACHT, but this may not always have happened. Once the first sibling group moved away from the foster carers compliance was reduced still further. No dialogue was initiated by either party to remedy this. In 2007 these children wrote to their social worker to say that they did not want to have any further health assessments.
- 6.157. For the second sibling group 5 out of the 8 required health assessments were undertaken between 2002 and 2005. Once the children left the foster home there is no record of any further health assessments. It is not clear whether they were held in the area to which the children had moved. Assessments should have been undertaken because the children remained looked after for several years. For these children more of the notes of these assessments show that there had been some interaction with the local authority i.e. there are some notes of LAC review meetings attached to the health records so that the health assessments were informed by an overview of the child's circumstances. There is no reference to sexualised behaviour in relation to one child where this was known to be a concern. The records show that it was the foster carers who brought this child to her assessments. In the circumstances they are unlikely to have mentioned it.
- 6.158. In relation to the children placed in the foster home after 2007 compliance with expected arrangements is much greater with only one out of six expected appointments missed. None of these assessments show any indication of concern about sexual abuse.
- 6.159. The evidence set out above described how the service worked prior to 2005. There was a review of LACHT in 2011 to ensure that the provision was modelled on best practice about how to meet the health needs of looked after children. The proposals recognised the need to strengthen information sharing, multi-agency working and case management, particularly for children who are cared for out of borough, to ensure that children were consulted directly and that their views informed their health care.
- 6.160. The inspection of the service undertaken by Ofsted in 2012 was very positive, though it is not clear whether the findings of that inspection drew on evidence on the health needs of children living out of the borough. A number of systems have since been put in place to seek to address their needs specifically. LAC nurses visit children placed out of borough to undertake their health assessments and have individual caseloads which allow them to follow up on recommendations of health assessments. This would have addressed some of the gaps in provision in this case. Electronic recording of clinical interventions, data collection and reporting of performance, has been improved and the LACHT administrator can update the children social care information system directly.
- 6.161. Appointments for health assessments are also proactively managed by LACHT without relying on social workers to initiate appointments. If a young person refuses an assessment the LAC nurses can investigate other sources of information to identify any health needs.

- 6.162. As these are all relatively recent developments the management review prepared by the trust indicates that performance in all areas needs to be the subject of regular audit and review so that there is evidence of a genuine integration of the LADHT with the work of social work services, particularly in relation to children who live at some distance from the borough.
- 6.163. The review has highlighted the vulnerability of looked after children to all forms of further victimisation. In order to have a better sense of children's emotional and behavioural development and to increase the likelihood of recognising at an early point when things are not going well the LACHT is committed to increasing the use of the Strengths and Difficulties Questionnaire⁴⁷ to screen children at the time of the health assessment.
- 6.164. The LAC health provider management review has made a number of recommendations in relation to these areas which the Serious Case Review endorses. Since the evaluation of health services undertaken for the Serious Case Review the local authority and the CCG have decided to commission the looked after children's health service from a different provider. It is therefore essential that the learning and recommendations arising from the Serious Case Review are implemented by this new organisation.

The role of the Local Safeguarding Children Board

- 6.165. The responsibilities of Local Safeguarding Children Boards (LSCBs) in relation to looked after children were set out in the statutory guidance for LSCBs in 2006 and 2010. Both versions of the guidance identify looked after children as being '*potentially more vulnerable than the general population*' and therefore likely to require specific services and procedures to safeguard their wellbeing.⁴⁸ The current Ofsted inspection framework expects LSCBs to provide '*regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children*'. The focus should include contact with safeguarding arrangements throughout 'the child's journey' including provision for looked after children.⁴⁹
- 6.166. From its inception, City and Hackney Safeguarding Children Board (CHSCB) focused on the core child protection responsibilities of the local authority and other member agencies, including the effectiveness of arrangements for referrals, thresholds for intervention, work with children who were the subject of child protection plans and the use of legal powers to protect children. This priority reflected the need to achieve sustained improvement in services for children from the low previous level
- 6.167. Between 2007 and 2012 the board developed an increasingly independent identity in relation to member agencies and widened its remit. From 2011 it developed more work in relation to wider groups of vulnerable children, including those affiliated to or affected by gangs, missing children and those at risk of sexual exploitation. These are both groups that include many children and young people who are looked after by the local authority.
- 6.168. In its 2012-13 annual report the board recognised that its work in relation to children who are looked after by the local authority '*has been limited*' and that '*applying detailed scrutiny to aspects of work will be a key challenge going forward*'. As a result the report acknowledges that it provides only '*a general overview*' of safeguarding for this group of children.⁵⁰ The annual report provides some detailed information on the work of LADO

⁴⁷ The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds.

⁴⁸ For example *Working Together to Safeguard Children 2006* Section 3.13 and *Working Together to Safeguard Children 2006* section 3.14.

⁴⁹ OFSTED (2014) *Framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers - Reviews of Local Safeguarding Children Boards*.

⁵⁰ City and Hackney Safeguarding Children Board, *Annual Report 2012-2013*

and arrangements for work in relation to children who go missing and those who are at risk of sexual exploitation.

- 6.169. Given the findings of the Serious Case Review in relation to the wider vulnerability of looked after children this is an area that needs more systematic development. This should take into account the findings of this report and Serious Case Reviews published by other LSCBs that have reviewed the provision made for looked after children and wider research.⁵¹
- 6.170. It is for CHSCB to determine its business priorities. Whether or not the safeguarding of looked after children becomes one of the priority areas in future business plans, the LSCB needs to develop mechanisms which enable it to have a much more detailed working knowledge of the quality of provision made for this group of children and their safety. The Serious Case Review has made a recommendation in relation to this.

⁵¹ http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/case-reviews-2014_wda101121.html; *HMI Probation, Ofsted and Estyn (2012) Looked After Children: An inspection of the work of Youth Offending Teams with children and young people who are looked after and placed away from home*

Specific terms of reference for the Serious Case Review

1. The effectiveness of processes for recruitment, assessment, approval and review of foster carers in the period under review and how they impact upon the safety and welfare of children, including processes for vetting and barring
2. Multi-agency agency practice around the care, welfare and review of children in placement
3. How and whether the voice of the child was able to influence practice and how children's views were sought, heard and listened to
4. Whether agencies, together or individually, missed opportunities to act on information that was known and knowable at the time, or information that should have come to light during subsequent reviews
5. The effectiveness of information sharing between agencies
6. Steps taken by the police and other agencies to investigate the possession or creation of unlawful images of child abuse at any time during the period under review – either specifically in relation to the foster carer or as part of major police investigations
7. The wider organisational context within which professionals were working over the timeframe of the review and any impact thereof

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings

Working Together to Safeguard Children 2013 (Sections 4.9 and 4.10)

Roles and membership of the Serious Case Review Team and Independent Review Panel

Review Team

The Serious Case Review has been conducted by a team consisting of the following:

- managers from the agencies most centrally involved in the Serious Case Review
- designated and named health professionals
- members of the City and Hackney Safeguarding Children Board including the Local Authority Designated Officer (LADO)⁵²
- a representative of the local authority and LSCB in the area where the foster family lived
- a representative of the LSCB in one of the localities where a number of the children who are the subject of the review now live
- a member of the Metropolitan Police Service Specialist Crime Review Group.

Meetings of the review team have been chaired by the lead reviewer and by the Senior Professional Advisor to the CHSCB. None of the members of the review team had any previous involvement with the children concerned or other family members.

Serious Case Review Team Membership	
Agency	Designation
City and Hackney Safeguarding Children Board	Senior Professional Advisor to the CHSCB (CHAIR)
	Business and Performance Manager
	Local Authority Designated Officer
Hackney Council	Head of Safeguarding and Learning
Metropolitan Police Service	Review Officer Serious Crime Review Group
City and Hackney Clinical Commissioning Group	Interim Designated Nurse, Safeguarding Children
Second Local authority	Head of Quality Improvement
Clinical Commissioning Group	Designated Nurse, Safeguarding
Third Local Authority Safeguarding Children Board	Programme and Performance Manager

⁵² The LADO is responsible for overseeing the investigation of allegations and concerns about the practice of professionals working with children. In Hackney the LADO works as part of the LSCB Business Unit.

SCR Independent Review Panel

The Serious Case Review has been overseen by an independent review panel made up of senior members of agencies from the local safeguarding network that had not provided services to the children. This group was led by the CHSCB Independent Chair. The review panel brought additional expertise to the review and offered scrutiny and challenge to the work of the review team.

Serious Case Review Independent Review Panel Membership	
Agency	Designation
City and Hackney Safeguarding Children Board	Independent Chair
	Senior Professional Advisor to the CHSCB
	Independent Lead Reviewer
	Local Authority Designated Officer
	Business and Performance Manager
The Hackney Learning Trust	Education Director
East London Foundation NHS Trust	Consultant Child and Adolescent Psychiatrist
Second local authority area	Independent Safeguarding Children Board Chair
Reporting to the panel	Independent Lead Reviewer

References

Statutory Guidance

HM Government, *Working Together to Safeguard Children – 2013*

HM Government, *Working Together to Safeguard Children 2006*

Disclosure of information as part of CRB / DBS checks

Home Office Circular 5/2005 *Criminal Records Bureau: Local Checks by Police Forces*

Home Office (March 2010) *A Balanced Approach - Independent Review by Sunita Mason Safeguarding the public through the fair and proportionate use of accurate criminal record information*

Home Office (July 2012) *Statutory guidance to Chief Officers of Police on providing information for inclusion in enhanced criminal record certificates*

Judgment R (on the application of L) (FC) (Appellant) v Commissioner of Police of the Metropolis (Respondent). [2009] UKSC 3 On appeal from: [2007] EWCA Civ 168

Police Act 1997

Protection of Freedoms Act 2012.

Procedural Framework for the inclusion of soft intelligence in DBS checks (known as QUAAF)
<https://www.gov.uk/government/publications/quality-assurance-framework-version-nine-qaf-v9>

Children's services in Hackney

City and Hackney Safeguarding Children Board, Annual Report
<http://www.chscb.org.uk/content/8/publications>

Ofsted, Inspection report for Local Authority Fostering Agency - London Borough of Hackney Fostering Team. (reports published in 2004, 2005, 2006, 2008 and 2010)

S Goodman and I Trowler (eds) (2012) *Social Work Reclaimed*, Jessica Kingsley; London

Sexual offending against children

Craven et al (2006) Sexual Grooming of Children: Review of Literature and Theoretical Considerations, *Journal of Sexual Aggression* 13(2) cited in Erooga (2012)

M Erooga (ed) 2012 *Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working With Them* (Wiley)

D Finkelhor (1984) *Child Sexual Abuse – New Theory and Research*, Free Press New York

R Tucker and J Still, (2009) *Staying Safe – Focused intervention for children and young people who live in families who have been affected by sexual abuse* Lucy Faithfull Foundation

Safeguarding of children and other references

Roger Barford (1993) *Children's Views of Child Protection Social Work*. Norwich: Social Work Monographs. (Social work monographs, no.120). NSPCC Library at QLJ JD, ISBN 1857840097

Nina Biehal, (2014) 'Maltreatment in Foster Care: A review of the evidence', *Child Abuse Review* Vol. 23: 48–60

Nina Biehal et al, (2014) *Keeping Children Safe – allegations concerning the abuse or neglect of children in care, final report* NSPCC York University

Sidney Dekker (2007), *Just Culture: Balancing Safety and Accountability*, Ashgate

David Finkelhor (2008) *Childhood Victimization: Violence, Crime and Abuse in the Lives of Young People*, Oxford.

Andrew Kendrick, *Who Do we Trust?: The Abuse of Children Living Away from Home in the United Kingdom*, Paper presented to the 12th International Congress on Child Abuse and Neglect; Protecting Children: Innovation and Inspiration, ISPCAN - International Society for Prevention of Child Abuse and Neglect, Auckland, 6-9 September 1998

Eileen Munro, *Effective Child Protection* (2nd edition)

Ofsted (2014) *Framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers - Reviews of Local Safeguarding Children Boards.*

Utting, W. (1997). *People Like Us: The Report on the Review of Safeguards for Children Living Away from Home*. London: The Stationery Office

Commentary on the Wakefield Council Local authority inquiry into the abuse of children by foster carers

<http://www.theguardian.com/society/2007/sep/12/guardiansocietysupplement.childrensservices>

Warner, N. (1992). *Choosing with Care: The Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes*. London: HMSO

Tara Weeramanthri, Child & Adolescent Psychiatrist, South London and Maudsley NHS Foundation Trust. London Safeguarding Board Conference

http://www.londonscb.gov.uk/files/conference07/6b.tara_weeramanthri.ppt An updated version of the presentation can be obtained from the author Tara.Weeramanthri@slam.nhs.uk

Serious Case Reviews on the abuse of children in foster care

Bridgend Local Safeguarding Children Board (April 2013) Executive Summary, Serious Case Review of the Circumstances Concerning Family T

Nottinghamshire Safeguarding Children Board (2011) Serious Case review DN 11

Rotherham Safeguarding Children Board (March 2010) Mr and Mrs B

B Parrott et al, Wakefield Metropolitan District Council Publication (2007)

<http://www.theguardian.com/society/2007/sep/12/guardiansocietysupplement.childrensservices>

Excerpts from the Hackney Children's Social Care management review describing the direct work undertaken with fostered children to establish their wishes and feelings

First sibling group

There is evidence that the children were visited, with some documentation about the children saying they liked their placement or were happy.

There was also positive feedback from the school about improvements in the children's behaviour, appearance and interactions with peers. The children did not attend statutory reviews. Statutory guidance at the time required only that children were consulted before their reviews. There is evidence of consultation with the children in advance of two statutory reviews. They also each completed feedback on the foster carers which formed part of one of the foster carer's annual reviews.

During this period, the foster carers' supervising social worker visited the family and regularly attended statutory reviews and there are seven documented visits where the children were either seen or spoken to by the supervising social worker. The reports during this time were positive about how the children were progressing in this placement.

Overall the documentation of this case makes it difficult to ascertain whether the children's wishes and feelings were sought on a regular basis during the placement

This makes it difficult to understand whether more or different interventions from professionals could have identified or prevented the abuse that took place.

Second sibling group

Throughout 2003 there were regular and well-documented home visits that document occasions when the children were seen individually on their own. In January 2004 an assessment was completed by a therapist who documented that she observed the children and spoke to them individually. This report demonstrates that the children were consulted about their future care arrangements and their feelings about potentially being separated from one another.

The turnover of social workers during their time with (the foster carers) and gaps in documented visits makes it difficult to judge the quality of social work involvement from July 2004 to December 2005. This lack of continuity and recording would have made it difficult for newly allocated workers to grasp the lack of progress in stabilising their behaviour that is evident when reviewing the file. This needs to be particularly considered in the context of a large sibling group where much of the focus of intervention was on care proceedings and family finding for the children. It is possible that some of the focus on future planning may have taken attention away from understanding the children's current experience in care.

Evidence from recordings and interviews suggests that there were some workers involved who did not have an appropriate level of skill to adequately understand or formulate an assessment the children's behaviour, including their sexualised behaviour, or challenge the narrative (about the cause of the sexualised behaviour) presented (the female foster carer). Due to changes in social worker at the time of placement move, the newly allocated worker was not able to formulate an accurate understanding of the challenging behaviour presented shortly after the placement ... which was viewed as 'extreme' but possibly normal for children with severed attachments from their birth family and then foster carers. At no time was there a disclosure about sexual abuse (by the foster carers) at the time of placement or throughout the intensive social work and therapeutic support that followed.

During their time with (the foster carers) the visits that took place generally met the statutory requirements, but this was not frequent enough for a worker to get to know the children well, especially in a sibling group with complex issues.

Some LAC Reviews were outside of timescale and the children were deemed too young ... to participate in their first statutory review. Current expectations would be that children of these ages should be able to participate in reviews in an age-appropriate form. There is, however, one example of the independent reviewing officer acknowledging that there was a need to consult with the children before the review, and purposefully booking in time to meet with the children in advance of the next review in June 2004.

Adolescent who moved to the placement in 2008

From the time when this child entered care ... there were ongoing conversations with her about her care plan. Particularly when her case was held in a (social work unit after 2007), there was a good standard of documentation that demonstrates ongoing work to support her and explore her wishes and feelings and regular visits by practitioners. The file indicates that (the child) had relationships with different professionals throughout her time in care, including social workers, the unit clinician, her school mentor and IROs and had regular opportunities to speak to professionals alone and in the presence of (the foster carers). There is evidence that the relationship she developed with the Consultant Social Worker allowed her to speak to him about matters arising in her family and happenings in her life, in person and through emails. For example, contact arrangements ...were a regular topic of conversation as this appeared difficult.

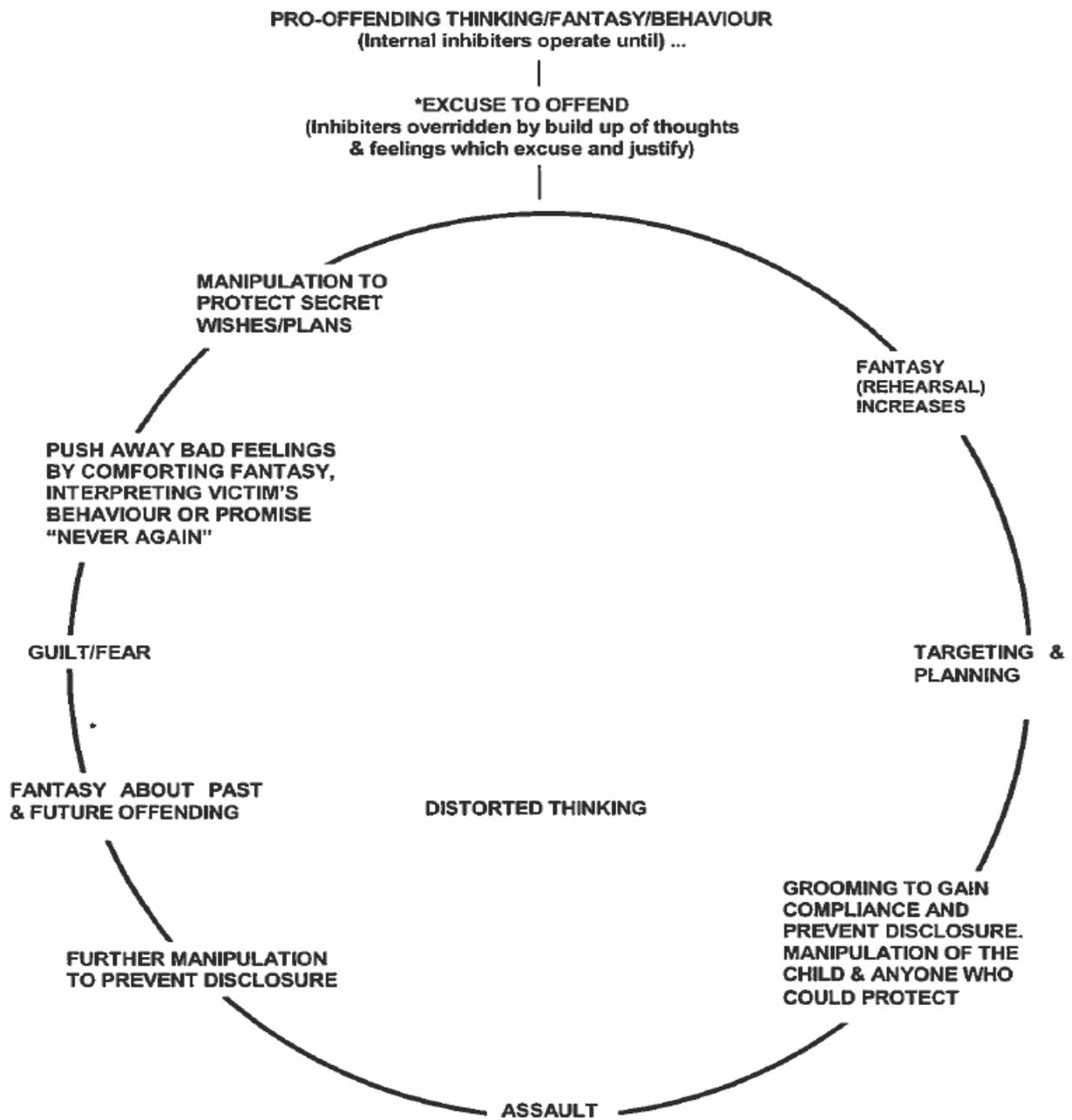
The file demonstrates that her views on this were considered and that she was supported in making her own decisions about this. The child clearly voiced her wish to remain in the care of (the foster carers) and this is evidenced in the documentation of placement visits, LAC reviews and (a court) report. At the end of the placement the work focused on (a care plan that was) in line with the child's wishes and feelings and agreed in consultation with (other relevant parties)...

Throughout this time there were no concerns raised about the care (that the child) received while placed with (the foster carers)

Primary school aged child who lived in the placement during 2007 - 2008

Due to the lack of recording on this file and the age of (the child) during the placement, it is difficult to understand her experience of care. There are recorded descriptions of her, but it is difficult to understand her wishes and feelings from the documentation available. There are some examples of her wishes and feelings being captured. For example... a report documents her (mixed feelings about the future) as she maintained loyalty to her birth family.

Basic Male Offender Sexual Abuse Cycle



Reproduced from
 R Tucker and J Still, (2009) *Staying Safe – Focused intervention for children and young people who live in families who have been affected by sexual abuse*, Lucy Faithfull Foundation