



Warwickshire Safeguarding Children Board

SERIOUS CASE REVIEW

CHILD T

Redacted report prepared by Naomi Bentley-Lawson based on the full SCR report.

1st March 2017

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INTRODUCTION

1. Background to the Review

1.1 Following his admission to hospital as a result of injuries sustained whilst in his mother's care, T had been placed with foster carers on 29 March 2013, and he became a looked after child. T tragically died on 30 June 2013. T was 23 months old at the time of his death and had been in the care of foster carers for three months when he was admitted to hospital as an emergency with non-accidental injuries. He was subject to an interim care order at the time of his death.

1.2 The foster mother pleaded guilty to the manslaughter of T and was sentenced in April 2016 to a term of imprisonment.

2. THE REVIEW PROCESS

2.1 The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learned from the case about the way individual agencies work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result;
- Improve individual agency working and inter-agency working and communications in order to better safeguard and promote the welfare of children¹.

2.2 WSCB appointed two independent consultants to lead the SCR. Their report was accepted in full by the board. WSCB had legal advice that the SCR report could not be published in full, and so an independent lawyer was commissioned to prepare this redaction of the report for publication.

2.3 A Panel of Senior Managers from each of the agencies involved was appointed to support the process.

The Scope of the Review

2.4 The period under review was from 12/12/2007 when the foster carers first expressed an interest in fostering children to 3/07/2013 when it first became

¹ Working Together to Safeguard Children, 2015

known that T had died as a result of non-accidental injury. Relevant background information concerning the period of T's short life, prior to his placement in foster care, was also included to inform the review and to put his death into context.

2.5 Family Composition at time of child's death:

T

Mother

Father: identity not confirmed, not included in this review

Maternal Grandmother

Foster Mother

Foster Father

Parallel Processes

2.6 An inquest into T's death was opened and adjourned on 12 July 2013, and was discontinued following the conviction of the foster mother.

2.7 The criminal conviction of the foster mother has been set out in paragraph 1.2

3. METHODOLOGY

3.1 The methodology used for this Serious Case Review has been a blended approach, incorporating: Independent Lead Reviewers, Chronologies and Individual Management Reports; a commitment to meetings with practitioners and their managers significantly involved with the case. These meetings proved particularly valuable in clarifying issues raised and informing the Serious Case Review process.

3.2 The LSCB in West Yorkshire - where the foster carers resided - was invited to contribute to the Serious Case Review.

4. SUMMARY NARRATIVE: KEY EVENTS

January 2009	Warwickshire County Council approved the couple as foster carers with the approval category of 1 child, 2 if siblings 5-10 years of either gender. Their first placement in October was uneventful, but the second placement of a 9-year old child in November proved difficult and the foster carers requested that he be removed.
December 2009	Concerns were raised about the emotional welfare of a child in the couple's care, raised by the psychologist and supported by the social worker. The local authority put further support into the placement. The placement irretrievably broke down a month later, and the foster carers had given notice to terminate the placement.
January 2010	The first annual fostering review noted concerns about the breakdown of this placement, and also recorded that the foster father had been rude to professionals. No action was taken about these concerns, but the couple's approval category was set at one child, two if siblings, aged 5-10 years, for short term or respite placements.
June 2010	The foster carers approval category was amended to cover the age range of 0-12, to reflect the placing of a younger child in January 2010.
July – September 2010	Two brief mother and baby placements were made with the foster carers which were outside of the foster carers approval category and extensions were not sought from the Fostering Panel, thus breaching regulations.
July 2010	Two children, under 5 were placed with the foster carers. The children's social worker had a number of concerns about the placement, especially the self-esteem and emotional well-being of the children. These concerns were discussed with the foster carers, particularly the male foster carer, who denied that there was a problem. The concerns raised about the care of the children were not escalated by the social worker, and no 'disruption of placement' meeting was convened as in fact the placement was not deemed to have disrupted but to have ended in an unplanned way at the wish of the social worker for the children.
January 2011	Two children under 4 were placed for a weekend in the placement. Their mother made a written complaint concerning inappropriate remarks made by the male foster carer about the older child. The complaint was passed to the supervising fostering social worker who went on long term sick leave in November. A fostering social worker to supervise the placement was not appointed until August 2011. Cover arrangements via the fostering duty desk

	<p>were available. There is no information available as to how/whether this complaint was dealt with.</p> <p>Second annual foster carers review took place. The approval status of the placement changed to one child, two if siblings, 5-10 years, plus one respite child 0-2 years. It was noted that the foster mother had given up her employment to become a full time foster carer and was more relaxed.</p>
December 2011	The foster carers moved house to Bossetshire, but remained foster carers for Warwickshire County Council.
March 2012	Foster carers annual review, which was presented to the Fostering Panel. Their approval status was changed to one child (two if siblings) aged 0-18.
June – September 2012	<p>Complaints raised by children in placement about rough handling by the carers, and a professional raised concerns about the way the children in placement were spoken about by the carers.</p> <p>The family were reported to be experiencing financial difficulty. The Practice Leader and the Fostering Social Worker visited to discuss the complaint with the foster carers. The foster father apologised but denied the alleged language used.</p>
November 2012	<p>Complaint by the mother of a child placed with the foster carers that the foster mother had allegedly slapped one of her children. The child subsequently said this had not happened. A Strategy Meeting was convened by Warwickshire children's social care who were unable to substantiate the allegation and no further action was taken.</p> <p>In late November, the foster mother went on holiday for three weeks, leaving the foster father to care for 4 children under six. Some help was offered by the fostering team to care for the children. No concerns were raised by either the fostering social workers about the appropriateness of this arrangement.</p>
November 2012	T was 15 months old at this time, and was taken to Hospital 1, A&E by Mother having sustained a head injury. The injury was considered to be consistent with the explanation given by his mother, but A&E staff were concerned about T's neglected presentation and a referral was made to the Emergency Duty Team.
February 2013	The Operations Manager visited the placement to address the complaints the foster carers had about the lack of fostering social work support they had received. The Manager agreed to take up their concerns with the team, but the foster carers subsequently gave notice to remove two children from the placement. The foster mother was particularly unhappy about the contact arrangements for these children.
February 2013	It was noted in supervision between the fostering social

	<p>worker and her manager that the foster carers “<i>should not take children as young as this again</i>”. However, their approval status remained unchanged and no urgent review was undertaken as to the suitability of the placement for young children.</p> <p>The foster carers annual review took place at the end of the month. Concerns and allegations about recent placements were shared with the Fostering Panel, no further action was taken and their approval status remained at one child of either gender, two if siblings aged 0-18.</p>
March 2013	<p>Mother took T to Hospital 1, A&E Department, with Mother’s current partner. On arrival at A&E T, who was 20 months old, was found to have a number of injuries, thought to be non-accidental.</p> <p>During T’s stay in hospital he was observed by the staff to be a lively child, running around the ward, happy and enjoying himself. The same liveliness was witnessed by the social work staff when he came to the Children’s Social Care offices before being collected by the foster mother.</p> <p>An ICO was granted by the Court, and T left hospital and was placed with the foster carers. He was five months younger than their youngest child in placement. The foster mother collected T from the Children’s Social Care office. No social worker accompanied T to the placement. The placement plan was drafted by the duty social worker.</p>
April 2013	<p>T was registered with the foster family’s GP, but was never taken to the surgery during his three month placement.</p> <p>During mother’s first contact session with T, T was observed to be pleased to see his mother, played with a balloon and ate some chocolate. Mother was to have 3 contact sessions a week for 1.5 hours at a contact centre.</p> <p>A Looked After Children (LAC) statutory visit took place on the same date. The foster carers raised concerns with the social worker that T was unsteady on his feet and that he ‘<i>seems to struggle to chew on one side of his face</i>’.</p> <p>They were also concerned that he could not use a beaker and was still using a bottle; that he was a ‘<i>fussy eater</i>’.</p> <p>Overall, the social worker concluded that T was settled in the foster home.</p> <p>4 April 2013</p> <p>Cafcass appointed a Children’s Guardian for T.</p> <p>Family Nurse (FN) visited T at the foster placement within 10 days of the placement. This was the first time she had met T. FN recorded that T’s weight and height were on the 91st centile and that he ‘<i>presented as quiet, withdrawn and</i></p>

	<p><i>seemed lethargic in his movements.</i>’ The foster mother reiterated that T was still using a bottle, was an unsettled sleeper and was unsteady on his feet. FN arranged to visit in 3-4 weeks’ time.</p> <p>The next day the foster father contacted the Fostering Social Worker 1(FSW 1) seeking advice as to whether he could replace T’s bottle with a cup. FSW 1 informed him that the foster carers needed to be supportive of T and wait for a suitable time to replace his bottle.</p> <p>In mid-April, an Initial Child Protection Conference (ICPC) was convened. The first Looked After Children (LAC) Review was held in conjunction with the ICPC, in accordance with the ‘dual status’ policy. Mother and her solicitor, as well as Maternal Grandmother, were in attendance at both meetings. The foster mother attended. FSW 1 was omitted from the invitation list.</p> <p>The major consideration of the ICPC and the LAC Review was the Police investigation concerning the injuries to T and the parenting assessment of Mother. Maternal Grandmother confirmed that she wished to be assessed as a carer for T. She later attended contact sessions with Mother.</p> <p>The foster mother stated that T had settled in well to the placement, he was now using a drinking cup. He was prone to tantrums, for which he was placed on the ‘time out step’.</p> <p>22 April 2013</p> <p>The foster carers had a supervision session with FSW 1. T’s injuries were discussed and the foster carers described how T could not chew his food properly, had a limited vocabulary, that he <i>‘whines and whinges a lot and seems to constantly seek food.’</i> They also stated that <i>‘he falls a lot and has poor balance’</i> and that.....<i>‘he possibly has hearing problems.’</i></p> <p>25 April 2013</p> <p>The couple with whom Mother had previously lived contacted Children’s Social Care to state that they wish to be considered as carers for T and wished to be part of the care proceedings. They were advised to seek legal advice, but when Mother indicated that she did not want them involved in T’s life, their interest was not pursued by the local authority.</p> <p>30 April 2013</p> <p>FN made a second visit to T. She noted that he was reluctant to explore and appeared to be <i>‘passive, still, very wary and hesitant.’</i> His Ages and Stages Questionnaire score was below the cut-off point. FN agreed to discuss</p>
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	<p>with Mother the need for a referral to the audiology clinic. The foster carers were advised to make a list of their concerns to be discussed with the Community Paediatrician at T's LAC Health Assessment. Later the same day FN visited Mother and Maternal Grandmother. Mother agreed to a referral to the audiology clinic and for Speech and Language Therapy. Both Mother and Maternal Grandmother told the Family Nurse that T was an active child before his admission to hospital, climbing on and off furniture. A second LAC visit took place. The foster carers told FSW 1 that they '<i>find it difficult to get a response from T</i>'. There was no record of liaison between the FSW 1 and the Children's Team Social Worker as to T's progress or whether the placement was meeting his needs.</p>
May 2013	<p>6 May T's Initial LAC Health Assessment took place. Both foster carers attended, but Mother and the Children's Team Social Worker were not present. The foster carers informed the LAC Community Paediatrician that T had difficulty chewing food and that he choked easily. They reported he was always hungry, had poor eye coordination and difficulty in interacting with other children. They also said his speech and vocabulary were delayed and that he fell over easily and could not run. Community Paediatrician noted that T listened to the male carer more and that he '<i>was very watchful</i>.' T's height and weight were not taken as part of the assessment. The Community Paediatrician concluded that T might benefit from extra help and made a referral to physiotherapy and portage.</p> <p>20 May T's contact with Mother was cancelled after the foster carer contacted the Children's Social Worker to say that T was unwell, possibly with chicken pox. The next day T attended an audiology appointment with the foster carer.</p> <p>24 May Mother's contact with T was cancelled due to the sessional worker responsible for supervising the contact being unwell.</p> <p>28 May A statutory LAC visit took place. T was described as placid. A referral had been made to Speech and Language Therapy.</p> <p>31 May The foster carers asked FSW1 if they could have another child placed with them. The request was refused and the FSW1 noted that the foster carers motivation for an additional child was financial. FN2 observed a contact session, where she noted that T's</p>

	<p>face <i>'lit up'</i> when he saw Mother. The Children's Guardian was also present at the session.</p> <p>The FN2 discussed T's placement with her supervisor and noted he <i>'is not thriving in foster care and is losing weight.'</i></p>
June 2013	<p>11 June</p> <p>The foster carers cancelled the contact with Mother, as they said that T was ill and thought to have chicken pox. At a Directions Hearing the Judge ordered the local authority to use <i>'its best endeavours to facilitate additional contact between T and Mother'</i>. Mother expressed her concerns to her solicitor about T's presentation and said that <i>'he is not the boy he was'</i>.</p> <p>12 June</p> <p>The contact session was cancelled by the foster mother as she said T possibly had chicken pox. This was the third session to be cancelled because of T having suspected chicken pox. T had not seen the GP throughout this period of illness, which had lasted almost a month.</p> <p>18 June</p> <p>The Court was informed that contact was not going ahead because of T's suspected chicken pox. Mother agreed for contact to be resumed once he was better.</p> <p>19 June</p> <p>A Family and Professionals meeting took place. Neither Mother nor the foster carers were present and it cannot be ascertained from the record whether they were invited. It was noted that the last four contact sessions had been cancelled.</p> <p>Mother's solicitor raised concerns with the legal department about T's presentation and that he was a <i>'much quieter'</i> child since being with the foster carers. This information was shared with Children's Social Care.</p> <p>21 June (a Friday)</p> <p>FN2 visited T at the foster home. The foster mother said she thought he had lost weight. T was weighed and was noted to have lost 2kg since being in the placement. The foster mother was told by FN2 to increase T's portion size at meal times and to take him to the GP if he is unwell. During this visit the FN2 completed an Ages and Stages assessment, and according to FN2 he performed all the tests adequately while sitting on her lap. On returning to her office the FN2 attempted to contact the Community Paediatrician and the Children's Team SW1, both of whom were unavailable until Tuesday, 25 June.</p> <p>25 June</p> <p>A contact session between T and Mother took place.</p> <p>26 June The foster mother contacted FN2 to explain that T's food intake had increased but that morning he vomited and appeared unwell. FN2 told the foster mother to take T</p>

	<p>to the GP and agreed to telephone later. The Family Nurse tried to contact the Children's Team SW1 but she was out of the office.</p> <p>The foster mother did make contact with the Children's Team SW1 and informed her of T's weight loss. She also contacted the Fostering Duty Social Worker to request that the contact session was cancelled, as T had been ill and was sleepy. On returning home, the foster father found T unresponsive and called the GP surgery. He was told to call an ambulance. T was taken by emergency ambulance to hospital in a state of unconsciousness.</p>
26 – 30 June 2013	<p>Wednesday 26 June</p> <p>14.30 T was admitted to Hospital 2. He was in a critical condition and was unresponsive. The history given by the foster carer was that he was seriously abused three months previously and was now in foster care. He had vomited earlier during the day and an hour later was found unresponsive. On initial presentation it was thought that there might be a medical cause for T's presentation. Consideration was also given to the possibility that T may have sustained a previous head injury, which could be related to his current condition. The most urgent need was to stabilise T and CT scans were required.</p> <p><u>On admission child protection concerns were not considered.</u> A CT scan showed T had suffered a bleed to his brain, which was described as 'relatively minor'.</p> <p>A further CT scan was conducted overnight, which revealed that T's condition was deteriorating.</p> <p>Warwickshire Children's Social Care Team were aware of T's admission. Warwickshire Fostering Service were also informed. This was on the basis that T was a Looked After Child. <u>At this time, no consideration was given to NAI.</u></p> <p>Mother and Maternal Grandmother were allowed to visit under the supervision of the foster carers. The foster carers were allowed to visit unsupervised and to stay overnight with T.</p> <p>Thursday 27 June</p> <p>Warwickshire Police only became aware of T's admission to hospital in the afternoon of the 27th when Mother contacted them to alter her date for signing on for bail, due to T being in hospital.</p> <p>T had retinal haemorrhaging in both eyes and further medical opinion indicates that this was probably the result of NAI. The Consultant Paediatrician's opinion that the</p>

	<p>injury was different to T's previous hospital admission at Christmas, and that the injury was highly likely non-accidental in nature, the possible cause being shaking of the child.</p> <p>T was seriously ill and his prognosis was poor.</p> <p>That evening, DS1 Bossetshire Police telephoned Hospital 2, Paediatric Intensive Care Unit (PICU) concerning injuries to another child. The doctor who answered the call assumed she was calling about T and informed her that T was on the unit, that he was a looked after child with an acute brain injury and was ventilated. On discovering that DS1 knew nothing of the circumstances of T's admission the doctor refused to disclose further details.</p> <p>On receipt of this information DS1 telephoned Emergency Duty Team (EDT) in Bossetshire County Council and was informed that they had no knowledge of T. The EDT Social Worker contacted Warwickshire EDT and was informed that T was a Warwickshire looked after child, that Warwickshire Children's Social Care was aware of his admission and were dealing with the matter. The EDT Social Worker concluded that T was the responsibility of Warwickshire and took no further action. No consideration was given to undertaking any further inquiries by EDT, even though T was a child living in their area, with a query NAI.</p> <p>DS1 then made contact with a staff nurse at Hospital 2 and was told that a 'Form A Safeguarding Form' had been sent to Warwickshire Children's Social Care. DS1 contacted Warwickshire EDT and was told that <i>'this was nothing to concern herself with as Warwickshire Children's Services managers; EDT managers and Nuneaton Police were dealing with it.'</i> The review has been informed that PICU staff contacted the on-call safeguarding nurse to inform her of T's condition. It was her responsibility to contact Children's Social Care, who would then inform the Police. This was the protocol for informing Police of suspected NAI.</p> <p>Having contacted DI 1, CAIU Duty DI, DS1 and DI 1 visited Hospital 2, PICU to seek further information about T's injuries. They noticed that the foster father was sitting by T's bedside, but did not make contact with him. Due to a number of emergencies on the unit, the officers were unable to ascertain much additional information about T.</p> <p>DS1 later succeeded in making contact with the</p>
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	<p>Safeguarding Nurse on duty, who informed her that the hospital Safeguarding Team had received a 'Safeguarding Form A'. DS1 was told that when T arrived at the hospital he showed signs of lacking oxygen, swelling and unequal pupils. He had retinal hemorrhaging and was due for eye tests the following day. Expert medical opinion had confirmed that the likely cause was NAI, possibly by way of shaking.</p> <p>Ophthalmic review. The children's intensive care registrar rang the on-call hospital safeguarding nurse to explain that following the ophthalmology review a potential diagnosis of NAI was suggested. The nurse said she would inform Children's Social Care and Police. The registrar advised that the Police were aware because information had already been shared, due to the confusion concerning the two safeguarding cases on PICU.</p> <p>Warwickshire EDT telephoned DS1 to update her on the situation.</p> <p>A Social Worker from the Bossetshire County Council EDT spoke with the on-call Safeguarding Nurse at Hospital 2. The EDT Social Worker explained that <i>"she is happy to do a joint visit to the home with the police that night, but because the child is under Warwickshire Social Care, she can only act at their request"</i></p> <p>23.23 Telephone call from Safeguarding Nurse, Hospital 2, to Warwickshire EDT to inform them that the outcome of T's ophthalmic review indicated that his injuries were the result of NAI. The EDT Social Worker informed her that Children's Social Care were aware of the circumstances of T's admission, and there was a social worker allocated to the case. The situation should therefore be left until the next morning. The Safeguarding Nurse expressed concern that there were other children in the foster home, however the EDT Social Worker said he was not aware of this and would liaise with Police.</p> <p>23.55 A nurse from PICU, Hospital 2, contacted the on-call Safeguarding Nurse to inform her that the foster mother was at home with other children. The Safeguarding Nurse rang Warwickshire EDT and left a message, but there was no call back.</p> <p>Friday 28 June DS1 made a number of enquiries with Hospital 2 about T's condition, Warwickshire Children's Social Care and Warwickshire Police. A safeguarding strategy meeting</p>
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	<p>was convened at the hospital. This involved Warwickshire and the Bossetshire Social Care, Warwickshire and Bossetshire Police, Hospital 2 Safeguarding Team and doctors from the PICU. A representative from Bossetshire Police major crime team also attended the meeting with CAIU officers. Warwickshire decided to undertake their own Section 47 investigation in respect of T. Doctors attending the safeguarding meeting were of the view that T's injury was of a non-accidental nature, but would not commit fully to this conclusion. Police requested that they be kept informed by Hospital 2 as to T's condition over the weekend and in particular if he died. It was agreed that the foster carers would not be allowed unsupervised contact with T. Following the meeting, Police Officers from Bossetshire CAIU visited the foster home and to take an initial account from the foster carers of events leading to T's emergency admission to hospital.</p> <p>Sunday 30 June</p> <p>Police received no contact from Hospital 2 as to T's condition. An officer from the CAIU finally spoke to a PICU doctor, who was reluctant to divulge information. It eventually transpired that T's condition had deteriorated and that he was 'brain dead'. The doctor explained that a meeting was taking place with T's mother and Warwickshire EDT to obtain permission for organ donation. The Officer expressed concern at such action, and explained that if T died, his death could potentially be a murder investigation. The doctor agreed to speak to the Coroner's office, who stated that organ donation was not appropriate in this case. T was declared dead and medical intervention was withdrawn. Following T's death, the foster mother pleaded guilty to manslaughter and another offence, and has been sentenced to a term of imprisonment.</p>
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ANALYSIS OF THE FAILURES IN THE SYSTEM

5. ASSESSMENT OF THE CARERS

- 5.1 The foster carers were approved by Warwickshire County Council Fostering Panel in January 2009 with the category of one child, two if siblings, aged 5-10 of either gender. During their fostering career they had a total of 23

placements, 11 very short term i.e. under 3 weeks, and 12 ranged from 1-7 months duration.

5.2 The Fostering Regulations and National Minimum Standards 2002 were in use during the time relevant to this Review, and were generally adhered to, with the exception of the period when the fostering social worker was on sick leave for a period of ten months.

5.3 The assessment of the foster carers met the key requirements of the Fostering Regulations 2002. The references raised no issues. The only negative comment at this point was from a family friend who felt the foster father might not be as committed to fostering as the foster mother, and that they had not been together as a couple for very long.

5.4 The analysis of the application did not uncover any breaches in the regulations of Warwickshire's Fostering Service. There is a view from this analysis and from an independent review of the fostering service conducted after the local case review following T's death, that there were no contraindications emerging for their approval as foster carers. However, it is significant to note that the fostering assessment did not include that the foster mother had experienced postnatal depression and in 2004 had attempted suicide following the breakdown of her marriage. Whilst it is not uncommon for prospective foster carers to have experienced significant emotional difficulties in their past, it is expected that these issues are raised by the prospective carers and fully explored with the fostering social worker in order to determine whether the issues had been resolved, and the carers would be able to manage the challenges of fostering. In this case such disclosure of relevant past information did not happen.

5.5 The lack of honesty and transparency on the part of the foster mother raises serious questions for this review, which continued to reverberate once the couple were approved as foster carers.

Practice Learning Points - Assessment

1. There was limited exploration of some aspects of the foster carers' lives and the effect these may have on their relationship.

6. SUPERVISION OF THE FOSTER HOME

Allocated Supervising Social Worker

6.1 Within the Fostering Regulations 2002 there was an expectation that once foster carers were approved they would have their own allocated social worker, and they would be visited by their supervising social worker at regular intervals. For Warwickshire County Council this was set at a minimum of four

monthly. In addition to this, unannounced home visits needed to be carried out at least at annual intervals. The purpose of the supervising social worker's visits was set out as having "*a clear purpose and provides the opportunity to supervise the foster carers' work*". The visits to the couple met requirements, apart from ten months when there was no allocated worker. During this period there is only evidence of a duty service response to the foster carers, and possibly one visit from a manager to carry out the annual review. This meant in practice that either the foster carers were responsible for 'self-reporting' incidents and/or concerns, or the children's social worker ensured that any issues relating to the care provided were escalated appropriately². This was a clear breach of regulations and did not support continuity of understanding and monitoring of this household.

6.2 Although there had been an absence of an allocated fostering social worker, by the time T was placed, one had been allocated. The review has been informed that one unannounced visit took place in July 2011, but this would have been insufficient to gain an insight as to how the couple were functioning as foster carers.

6.3 *Additional information has been provided to the review from direct interviews with Fostering Managers concerning management arrangements for the service at that time. The service was then managed through the locality Social Work Teams. This meant it was difficult to provide cover for absent social workers. The service has since been brought together. This allows for economies of scale and practice has changed to ensure that where a fostering social worker is absent for longer than three months, another worker is allocated to the case. There are also now named Social Care Workers in post, who are not qualified Social Workers, but who maintain contact with carers.*

Reviews of the Foster Home

6.4 The Regulations also stipulated that annual reviews of a foster home should take place, and more frequently if any issues were raised. It is Warwickshire County Council policy for these reviews to be taken to the Fostering Panel, which is good practice and exceeds the standards. It would be expected that any comments, concerns or complaints raised during the period since the last review were considered, and that there was a full discussion of any training needs or requirements for formal change of status which might arise out of this. The 2002 Regulations stipulate that the fostering service provider when reviewing a foster home should "*make such enquiries and obtain such information as it considers necessary in order to review whether the person continues to be suitable to act as a foster parent*". It does appear that the annual reviews took place on time, but there is little evidence of concerns being considered in a cohesive way, thus there was a lack of opportunity to put together the sequence of events and concerns, which with hindsight, can

² During the period from November 2010 – August 2011 when there was no supervising fostering social worker, no incidents were reported.

be seen to be accumulating. Whilst poor performance by the foster carers could not perhaps have been predicted from the assessment, their actual performance was questionable from very early in their placement history.

- 6.5 Reviews were held on time, (save for one) and recorded, but there was an absence of detailed comment from the social worker as a result of sick leave and the failure to allocate a new worker. Given the limited contact the Fostering Team had with the foster carers during this period it is surprising that there was seemingly no challenge from the Panel as to the accuracy of the information in the review. Information about the concerns which had arisen about the care offered to some children in the placement was not shared with the Panel, as it was not included in the annual reviews. The lack of robustness in the annual reviews was a lost opportunity to begin to collate concerns and alert practitioners. It is however, important to note that the couple were considered to be experienced foster carers. Support that was given, was seemingly on the basis of supporting them as foster carers, rather than consideration being given to the safeguarding needs of children in their care.

Absence of fostering social worker

- 6.6 The independent review of the fostering service in December 2013, assessed the quality of case recording of the Fostering and the Children's Social Care services. This Review was commissioned by Warwickshire County Council. The conclusion reached was that the recording was broadly within guidelines, in that it was timely and detailed. However, there was a lack of analysis and on several occasions there were discrepancies in the detail. Overall, it can be said that there was a distinct lack of clarity about how concerns raised about the foster carers were followed up.
- 6.7 The same assessment can be made of the management oversight of the fostering social work practice in this case. There is evidence of managers' comments and some supervision but the analysis is lacking, and there are few indications of management direction following concerns, apart from the joint visits on a couple of occasions to the foster carers.

Training undertaken by foster carers

- 6.8 There is an expectation in the Regulations that foster carers are offered and will take up training, including additional input if there have been any issues raised. There is evidence of basic training being undertaken by the couple, particularly the initial training sessions for foster carers, and Skill level 1 in August 2008, and later Skill level 2. By September 2010 they had completed the standard Children With Disabilities Care course required at that time. However, there is little record of training after this, only four courses between the two carers, which included the foster father attending a 'Men in Fostering' course and an attachment course. There is, however, no indication that given the concerns which had been raised about the lack of understanding, particularly on the part of the foster father, concerning child development and the trauma often experienced by children looked after, of the foster carers

requesting, being provided with or attending training in these crucial areas. This is illustrated by the lack of empathy or understanding of T's needs shown by the foster carers when he was first placed with them. T had suffered non-accidental injuries whilst in his mother's care, including an injury to his mouth. Within days of T's placement, the foster father was informing the social worker that T had problems chewing and could not chew out of one side of his mouth (seemingly not equating this difficulty with the injury T had suffered). At the same time the foster father requested that T be trained to use a cup and that his bottle be removed. This was in the context of a 20-month old child who had experienced not only the trauma of physical injury, but who had also spent several days in hospital and had then been placed into a strange environment with people whom he had not previously met.

6.9 The expectations of the foster father that a child who had been as traumatised as T could adapt to behaving in the same way as another child of that age, with whom T was on occasions compared, was not only unrealistic but also showed a complete lack of understanding of the needs of a vulnerable child. It is evident that there was a significant gap in both the foster carers knowledge of the needs of the children they cared for, which should have been recognised by the supervising social workers. Consideration should have been given to put in place increased supervision and for their attendance at additional training.

6.10 It is significant to note additional changes which have taken place in the Fostering Service since T's death, which include:

- *managers signing off all referrals to fostering;*
- *the Fostering Operations manager approving all exemptions to foster carers approval in a timely manner, i.e. where carers exceed the number of children for whom they have been approved;*
- *All extensions to approval categories now go to the Fostering Panel for decision, i.e. mother and baby placements and age range changes.*

Practice Learning Points – Supervision of the Foster Home

1. Whilst there was recording of the fostering assessment, annual reviews and contact with the foster carers, there was a lack of critical appraisal of their skills, and gaps in supervision at key points, by the fostering social worker. It is important to recognise that the role of the fostering social worker is to take into account not only the needs of the foster carers, but most importantly the needs and wellbeing of the child in the placement.
2. The need for regular and consistent supervision of foster placements is crucial for the safeguarding of children, especially nonverbal/pre-school children. In this case the foster carers were without the oversight and support of a Fostering Social Worker for ten months. The onus was on

the foster carers to bring any issues to the attention of the Fostering Duty Social Worker or for the Children's Team Social Worker/s to report any concerns about the care of the children in placement. This was a clear breach of regulations and did not support continuity of understanding and monitoring of this household.

3. There was seemingly no challenge from the Fostering Panel as to the accuracy of the information presented, given the limited contact the Fostering Team had with the foster carers during this period. The overall lack of robustness in the annual reviews was thus a lost opportunity to begin to collect concerns and alert practitioners. Both social workers and the Fostering Panel need to consider and question whether information is missing or unavailable, when reports are prepared and when they are presented.
4. There was a lack of recognition by fostering social workers of the gaps in the knowledge and understanding of child development and attachment theory on the part of the foster carers. This was evident in the unrealistic expectations the foster father clearly expressed about T. The need to robustly challenge such views and to ensure that suitable training is made available to and taken up by foster carers is an important finding of this review.
5. The need to share information between teams within a local authority cannot be overemphasised. The sharing of important information did not happen in this case. There is now in place the means for such information to be readily accessed electronically by all social care practitioners working with looked after children. It is anticipated that the findings of this review will enhance and strengthen the use of this facility.

7. INFORMATION SHARING

- 7.1 The table of Key Events sets out a number of issues with the performance of the foster carers, which were not appropriately investigated and recorded, which in turn meant that the information was not shared.
- 7.2 The second Foster Carers Review in January 2011 changed the status of placement to one child, two if siblings, 0-12 years plus one child 0-2 years, short term or respite. This seems to be an acknowledgement that the foster carers were less effective with two children in placement, but there is little evidence that this was complied with in further placements.
- 7.3 The third annual Fostering Review took place in March 2012. At this point their approval was changed to one placement, two if siblings of either gender, aged 0 to 18, which was in line with the new fostering regulations introduced in 2011. In the case of these foster carers it seems to have

been done without adequate reflection on how they managed younger children or what they could offer to older children. There is little evidence of any analysis of the couple's abilities or skills.

- 7.4 In June 2012, a 10-year old girl was placed with the foster carers on an eight day respite basis. She complained that the foster carers had roughly handled her and another child in placement. Information contained in Warwickshire records states that the incident was discussed by the Social Worker in Warwickshire with the Allegations Manager (LADO) for Bossetshire, but from information available it seems that no investigation was initiated by either the Bossetshire or the Warwickshire LADO. A decision was reached between Fostering and Children's Social Care in Warwickshire that the issue should be regarded as one which could be dealt with by the foster carers receiving training. However, no evidence was seen by the Review as to whether this training took place. There is no information available as to whether the allegations were fully investigated, as there was no Strategy Meeting.
- 7.5 The importance of detailed and timely recording of concerns related to the care of children looked after by foster carers cannot be underestimated. If the issues raised in the career of the foster carers had been appropriately investigated and recorded, it may have possibly made a difference to the future placement of children with these foster carers, including T.
- 7.6 This Serious Case Review has highlighted the complexities as to which Local Authority Designated Officer, (LADO) undertakes an investigation into allegations against foster carers who are employed by one authority, but reside in another³. It is apparent that the need for LADOs involved in such cases to communicate with each other is crucial, if allegations concerning the care of children are to be appropriately investigated. It is understood that since the tragic death of T, the regional LADO group which includes Bossetshire has discussed cross boundary working practices and have agreed a working protocol of how such cases are dealt with.
- 7.7 It is recorded that the foster carers had serious financial difficulties, however, these were never analysed by any fostering social worker. Such financial constraints need to be seen as instrumental in the foster carers motivation to have additional children placed with them.
- 7.8 In August 2012 a professional raised concerns about how the foster carers spoke about a young foster child in their care, in a derogatory manner.

³ Position of Trust procedures are normally overseen by the LADO covering the local authority area in which the adult works. With foster carers there is ambiguity about whether the work address is their home, or if it is the office address of the agency/local authority by whom they are employed. The Serious Case Review has been informed by the Bossetshire LADO that it is their practice to investigate allegations against foster carers from independent agencies if they are resident in their area. In the Bossetshire Region, allegations against local authority foster carers would be investigated by the employing LA regardless of where they are resident.

Some of the comments made about this child were to resonate when T was later placed with them. There was some appropriate follow up to these concerns, in that the Practice Leader and the Fostering Social Worker visited together to discuss the complaint. The foster father apologised, although he denied using the precise language as was stated. This was a sign that the foster father did not fully appreciate how inappropriate his comments were and it is of concern that this was not followed up with, for instance, a proposal for training on child development.

- 7.9 In November 2012 the mother of a child placed with the foster carers notified her solicitor of an allegation made by her child that the foster mother had slapped her. It is evident that the way in which this allegation was investigated by Warwickshire Children's Social Care and the Fostering Service did not comply with child protection procedures. There was no liaison with the Bossetshire LADO, Children's Social Care or the Bossetshire Police. When the foster father subsequently told the fostering social worker that the foster child had withdrawn the allegation, this was not followed up with the child. An interview under ABE procedures,⁴ did not take place. A child protection medical was not undertaken, and neither was a Section 47 investigation instigated. The matter was referred to Warwickshire Police, and a Strategy Meeting was convened by Warwickshire Children's Social Care at the end of November 2012, however, no other agency attended, including the Police. The outcome was that no further action was deemed necessary.
- 7.10 An extract from a supervision session in February 2013 between the fostering supervising social worker and her manager notes that the couple *"should not take children as young as this again."* The significance of this comment was however not available for the Fostering Panel to consider, as the report presented as part of the foster carers annual review to the Panel on 25 February 2013 had been prepared by the social worker ahead of the meeting. The social worker did not attend the Panel and there was thus no update available. As is procedure in Warwickshire County Council (then and now), the review was presented to the Panel by a Practice Leader. Practice Leaders attend on a rota basis and in this instance, the Practice Leader presenting the report was not the Practice Leader responsible for supervising the case. Although some of the concerns and allegations were shared, crucially the assessment that the couple should not take very young children was not included in the report. No further action was taken and the approval status remained at one child either gender, or two if siblings, aged 0-18 years. There was no urgent review of the foster home, nor was any consideration given to drawing up an action plan to address the concerns and allegations raised, as the Fostering Panel did not have the full updated information about the household.

⁴ ABE: **Achieving Best Evidence** in Criminal. Proceedings. Guidance on **interviewing** victims and witnesses, and guidance on using special measures. March 2011

- 7.11 The lack of questioning by the Fostering Panel of the concerns which had been presented to them, was a missed opportunity for the placement to have been robustly reviewed and for the financial pressures the couple were facing to be explored. In addition, the system in place for presenting reports to the Panel was reliant on the Practice Leader having a grasp of the case, based on the report prepared by the fostering social worker. The concern, expressed by the social worker during supervision was missing from the report to Panel. Although this was an important omission, a system which relies on Practice Leaders presenting reports, rather than the fostering social worker, can only succeed if the report is comprehensive and there is sufficient time for the case to be fully discussed between the presenting Practice Leader and the social worker. This did not happen in this case, which in turn led to T being placed with the couple. It is of concern that given the same procedure for presenting reviews to Panel is currently in place, similar concerns about foster placements may be missed. This is a lesson learnt from this serious case review, resulting in a recommendation being made for the LSCB to consider. Practice Leaders are currently known as Team Managers in Warwickshire Children's Services.
- 7.12 The end of placement report for the two children who had moved in January 2013 was completed on 5 February 2013. The report noted that the match was not ideal, and that contact arrangements had caused problems. It is of significant concern that the placement of T, a child of a similar age, who would have required contact with his mother, was placed with the couple so soon after the breakdown of this placement.
- 7.13 The concerns raised by Mother and Maternal Grandmother with Children's Social Care about the changes in T's presentation whilst in the foster placement were noted but not acted upon by the children's team social worker.

Practice Learning Points – Information Sharing

1. There were concerns from very early on in the couple's fostering career. However, there was a lack of rigorous monitoring of their development skills as carers, and too little communication between those professionals who had knowledge of the household. Essentially these were safeguarding concerns.
2. Concerns were not followed up, as expected by the fostering regulations, and neither were they fully considered in the context of child protection.
3. If concerns about the placement had been reviewed and assessed, it would have revealed that:
 - the foster carers had difficulty meeting the needs of children unless they were very straight forward;
 - they struggled with placements where the child had learning difficulties and where children had attachment issues. Indeed, they showed very little understanding of attachment theory and the link

with child development;

- they found it difficult to work with parents, particularly in relation to contact;
- at times there were indications the foster carers were under financial stress, but the impact of this on their capabilities as foster carers does not seem to have been understood or explored.

- 5 Over the four years of fostering children, the foster carers experienced difficulties working with several parents of children placed with them. In all, there were 7 concerns raised about their care of children. In turn, they made complaints about professionals and at times threatened and subsequently gave notice for children in their care to be removed when the placement became too difficult for them to manage. These issues were not viewed from a holistic perspective by professionals supervising the placement, which enabled the foster carers to continue to have vulnerable children placed in their care.
- 6 Only one of the concerns or allegations raised about the foster carers were escalated to the LADO in either Warwickshire or Bossetshire. Whether this was because there was a lack of awareness of the procedure and criteria for making a referral is not known. However, it is apparent from the practitioners' meetings set up to inform this review that there continues to be a lack of awareness across agencies in Warwickshire as to the function of the LADO. A number of practitioners attending the meeting were unaware of the LADO's role or the criteria for making a referral.
- 7 Where concerns arise about the approval category of a foster carer, i.e. the number and age of children placed, such information needs to be incorporated into fostering reviews.
- 8 A system which relies on Practice Leaders presenting cases, for which they have no direct responsibility, can lead to important information not being presented to the Fostering Panel.
- 9 There was little seeming awareness on the part of those professionals working with the foster carers of the requirement to consider the welfare of the children in their care from a safeguarding perspective.

8. PLACEMENT PROCEDURES

- 8.1 T's placement with the foster carers was an emergency placement. The review has been informed that there is a requirement for social workers to explore all options for 'in house' foster placements to accommodate children before looking at external providers. The foster carers had a vacancy; the request was within their approval category and they had previous experience of young children. Although the Fostering Social

Worker was on annual leave when the request for the placement arose, there was a note on the fostering board to discuss any placement with her before a child was placed. There was, however, no indication as to why the social worker should be consulted first or that children should not be placed with these foster carers. The recent note in supervision that children this young should not be placed with the couple was not on the foster carers case record, and this information had not been recorded on the fostering review or passed for consideration to the Fostering Panel. There was no record of complaints on the foster carers record, as the concerns raised were not recorded as formal complaints. Given there was no written information to indicate the placement should not be used, in the absence of the Fostering Social Worker, the placement was discussed with the Fostering Duty Practice Leader, who agreed the placement could be made.

- 8.2 On her return from leave, however, the Fostering Social Worker did not review the placement, given the concerns expressed to her Practice Leader in supervision. This was a missed opportunity to assess whether the placement met T's needs, but it perhaps also needs to be seen in the context of Key Performance Indicators in place at the time (and still current) that looked after children should not have more than three placement moves. However, the Review found that it is more likely that this missed opportunity to review T's needs within the placement arose more from the pressures on the fostering system to focus on new referrals and children coming into the system, rather than reconsidering apparently settled placements which are within approval categories, such as T's.
- 8.3 The placement was arranged by the Duty Fostering Social Worker. T was placed in spite of the close age of other children in the placement. He was admitted straight from hospital with no placement meeting, and the Placement Plan was drafted in the Children's Social Care office and not in the carers' home with their involvement. No social worker accompanied T to the foster home, as he was taken from hospital to the office by a duty social worker and then collected by the foster mother, who took him home. This did not comply with placement guidelines and was not good practice. When the question was asked of practitioners at the meeting held to inform this review, as to why no social worker accompanied T to the foster placement, no explanation could be provided.
- 8.4 *It is recognised that since T's death, an improved database is available for placing children by duty social workers, which includes more detailed information about a placement. However, there is no guarantee that sufficient 'soft' information, i.e. concerns about foster carers, but which are not formal complaints, are recorded on the system, and it is possible that important information concerning the appropriateness of a placement continues to be missed. This is a lesson learnt and is a recommendation arising from this review.*
- 8.5 Like many other local authorities, Warwickshire County Council struggles at times to find placements for children and there was evidence that the

couple were used on a number of occasions to place children outside their approval category. Whilst not an uncommon occurrence, this may be seen as contributing to poor standards of child care within foster placements, and needs to be considered in light of the particular financial pressures the foster carers were facing at the time of T's placement, which was known to the fostering service, and should have been seen as contributing to stress. The issue was very slow to resolve and there is very little comment in the recording about the implications or the likely impact on the household.

Practice Learning Points Placement Procedures

1. The importance of formally recording decisions/recommendations in fostering reviews and with the Fostering Panel about the appropriateness of the placement of children with foster carers is crucial if tragedies such as occurred in this case are to be avoided. Such information needs to be easily accessible to placing social workers and needs to be flagged on the data base of available foster placements.
2. There is a need to take into consideration the closeness in age of children already in a home when placing any child, including when in emergency circumstances. Where such placements cannot be avoided the need to review the appropriateness of the decision made as soon as possible is of the utmost importance to maintain the welfare of the child. No such review took place in this case when the supervising fostering social worker returned from leave and undertook responsibility for the placement.
3. No social worker accompanied T to the foster home, as he was taken from hospital to the office by a duty social worker and then collected by the foster mother, who took him home. This did not comply with placement regulations and was not good practice.
4. When a child is admitted to foster care, it is best practice for a placement meeting to take place, within 5 working days, at the foster home, to draft a placement plan, with the foster carer/s, the child's social worker, the fostering social worker and the child's birth parent (if no risk is presented by the birth parent to the placement) to be present. This did not occur in this case, as the placement plan was drafted in the Children's Social Care office. This was a lost opportunity to compare how T was at that time before he was placed the foster home.
5. There were indicators that the foster carers were under some financial pressure, however, this was not fully explored or monitored by those supervising the placement. Financial difficulties are not necessarily an indicator of a safeguarding concern in a foster placement, however it was of particular significance in this case as their difficult financial

circumstances proved to be a key part of the foster carer's motivation to foster children.

Information Sharing for Placement

- 8.6 The foster carers were aware of the circumstances of T's admission to hospital and concerns about Mother's behaviour and actions. The placement occurred at a time when there were minimal numbers of staff working.
- 8.7 At the time of the placement, the information provided about T on the referral form to the Fostering team was largely concerned with the reasons for his accommodation rather than with his individual needs. This was reasonable, given that it was information gathered from hospital staff and the Emergency Duty Team, including T's 'boisterous' behaviour. No information was gathered from his mother who could have provided helpful information about his behaviours, preferences and personality. This meant that the foster carers did not have a full picture of T's needs or a detailed care plan when he was placed. However, it is significant that although they made clear on several occasions to the Social Worker, the Fostering Social Worker, Health professionals and the Children's Guardian their difficulties in meeting T's needs, and raised concerns about his cognitive ability, there is no evidence to suggest that the foster carers actively sought further information about T's background. Neither did they seek advice about how best to support and care for a child who had experienced significant trauma prior to his placement.
- 8.8 Although T was referred to Portage Services⁵, he was not considered to be a child with disabilities. The health information provided to the Community Paediatrician showed no indication of concerns of a chronic nature of health complaints or conditions. There were no suggestions from medical information that a diagnosis of disability had been given in response to the injuries he sustained.

9. CONTINUITY OF PROFESSIONAL INVOLVEMENT WITH T

- 9.1 From the time of T's admission to hospital in late March until his tragic death in June 2013, there were three social workers, as well as social workers from the Emergency Duty Team who were involved with him during his two hospital admissions. In addition, there was the Fostering Social Worker responsible for supervising the placement. Apart perhaps from the sessional worker who supervised contact, it was the Fostering Social Worker, of all the social care professionals, who had the most consistent contact with him during this three-month period. However, the

⁵ Portage is a home visiting educational service for pre-school children with additional support needs and their families

focus of her role was to support and supervise the foster carers rather than to work directly with T. Thus, her main knowledge of him would have been derived from her observations of T when she visited the foster placement and from information supplied by the foster carers. It is evident that she had expressed concerns about the financial motivation of the foster carers for wanting more children to be placed with them, as well as concerns that the foster mother was '*over medicalising*' the children in her care, particularly T. None of these concerns however appear to have been fully explored or escalated.

- 9.2 It is concerning that as a result of systems issues, the Fostering Social Worker was not invited to the Looked After Children (LAC) Review, which immediately followed the Initial Child Protection Conference on 12 April 2013. As a result of not being invited to the first LAC Review, she was not on the list of professionals to be part of the Family and Professionals meetings which followed. Had the Fostering Social Worker been present, she would have been provided with the opportunity to gain a fuller understanding of T through such information sharing meetings. The oversight of the Fostering Social Worker not being invited to the LAC Review was seemingly not queried by the Independent Reviewing Officer.
- 9.3 The social workers from the Children's Team did not know T well. The first Social Worker (SW1) undertook the initial work which concentrated on the initiation of care proceedings. The second Social Worker (SW2) met T through her visits to him and work with Mother (SW2 was undertaking a Parenting Assessment of Mother). The case was then transferred to a third Social Worker (SW3) on 23 April 2013 who was newly qualified, but who was not receiving supervision in accordance with the requirements for newly qualified social workers. This meant that she did not receive sufficient oversight or support in her dealings with the foster carers. This is especially important given the past history of concerns about the couple as carers, and at times the intimidating behaviour of the foster father.
- 9.4 The transfer of the case at a number of key practice points, (as part of the organisational structure in place in Children's Social Care at that time) led to a situation where no one social worker had overall personal knowledge of T. Little information was gathered from Mother or for that matter Maternal Grandmother about T's needs, his likes/dislikes or his behaviour at the time he was placed in care or at any time thereafter. No one sought to gain information about T from the two people who possibly knew him more than any other carers, namely the friends with whom Mother and T had lived. The lack of consistency of social workers allocated to T, led to a situation where no one, apart from Mother, had an understanding of the changes in his behaviour. When Mother did raise such concerns, they were noted, but no action was taken to investigate what was causing such an obvious change in T's presentation.
- 9.5 The structural organisation of Children's Social Care at the time led to a situation where a vulnerable child did not receive consistent supervision from a social worker who had comprehensive knowledge about him as a

child in his own right. This can be seen as a systems failure, which if the same structure is still currently in place could lead to other children being placed at similar risk. *The Review learned that there has since been a restructure in Warwickshire's Children's Services which has reduced the number of potential transfer points in a child's case.*

- 9.6 The Community Paediatrician who undertook the LAC health assessment of T had not met him before. Neither Mother nor a Social Worker were present at the medical to provide any information about T. The Review was told that there are challenges in the current system for booking Health Assessments and arranging transport to enable parents and carers to attend⁶. *This is currently under review to ensure a meaningful Health Assessment can be held within timescales with the appropriate people present.* Although the Community Paediatrician liaised with Hospital 1 about the extent of his non-accidental injuries, of necessity she had to rely on information provided by the foster carers as to T's behaviour and perceived health needs. Based on the information provided, the Community Paediatrician assessed that T might be in need of additional support in the form of speech and language therapy, physiotherapy and portage services and made appropriate referrals. It is clear from information provided to the review that there was not a single understanding on the part of professionals about the role and responsibilities of the LAC doctor.
- 9.7 There was no contact with a GP during T's placement. T was registered with the foster carers' GP Practice on 12 April 2013, however he was never seen by a GP. It would seem from information provided that the GP was unaware that this household was fostering children. Neither was the Health Visiting Service involved with him, as he and Mother continued to be part of the Family Nurse Partnership Programme.
- 9.8 FN saw T on four occasions during the review period. All of these occurred whilst he was a Looked After Child and in fact FN was the last professional to see T before his catastrophic brain injury. Three of the visits were at the foster carers' home and the other was during a contact session with Mother. It was noted by FN that whilst medically T was felt to be satisfactory he was displaying watchful behaviour and was described as '*traumatised*'. These observations were considered in the context of T being separated from his Mother and being placed in local authority care. Because she had no contact with T whilst he was cared for by his mother, she understood that the rationale for his presentation as being 'withdrawn' was due to T being separated from his mother. This can be said to be reinforced by her description of T during the contact session with Mother, which FN attended, when she said '*he lit up*' when Mother was in the room.

⁶ Warwickshire is a rural county and community paediatricians are based all over the county, as it is not a localised service. Thus, assessments are often held in central locations.

- 9.9 If the description provided by FN of T as a watchful, wary child, who did not move easily, interact or play with others, and who had lost 2 kg in weight over a period of 12 weeks, had been made of him when he was living with Mother, it would have raised serious safeguarding concerns. That T was in the care of trusted foster carers meant that such a presentation was seen in the context of him being separated from Mother. There was a lack of professional curiosity as to whether there might be another underlying cause. It was evident however, that FN was beginning to feel uneasy about T's dramatic weight loss and just days prior to his death she attempted to raise this issue with SW3 and the Community Paediatrician, but neither was available at the time.
- 9.10 The Children's Guardian observed T during two contact sessions with Mother. She did not visit the foster placement from the time she was allocated the case, and relied on telephone conversations with the foster carers to inform her of whether T was settled and how he was progressing in the placement. She thus had no direct knowledge of T's interaction with the foster carers compared with how he interacted with his mother. This would have been a significant observation for two reasons. Firstly, as a Children's Guardian she was required to comment upon the child's relationship with his mother and her ability to meet his needs. Secondly, the Guardian would normally be able to rely upon the foster carers as being approved and skilled carers of children in a way that the mother may not have been. The contrast between the child's responses to the different quality of care could have provided an insight into T's needs, development and progress, and enabled the Guardian to comment upon the mother's concerns about the changes in his presentation and behaviour. These concerns, given the knowledge of what we now know was happening in the foster home, proved to have been prescient. It would have been a reasonable expectation for the Guardian to have taken account of Mother's views about T's change in presentation.
- 9.11 The Children's Guardian's role is to comment upon what is in the best interests of the child, and not to just accept that because the foster carers had been assessed as appropriate to care for T, there was no reason to believe this was not the case. Whilst not an explicit part of her duties and responsibilities, as set out in the relevant Practice Direction 16A for Guardians, if the Guardian had visited the foster placement, she would have gained valuable insight into the presentation of T in the placement as opposed to with his mother during contact. The Review considered that it would have been best practice to carry out this visit at an early stage, in order to strengthen the Guardian's analysis of the child's needs. Direct observations of T in his home setting might have triggered concerns about the inconsistency in the accounts of his behaviour and development. The Guardian has informed the review that she intended to visit the foster placement as part of her investigations, but would not have anticipated doing so in the early months of T's placement, preceding his death. The Review accepts that the Guardian was working within the Practice Direction, but considers that the guidance was problematic in the context of a young pre-verbal child. The Practice Direction does not address the

needs of these children, where information collection is more complex and requires direct observation of the child. T's behaviour showed clearly that he was miserable and at times hungry. The fact that the Practice Direction does not stress the value of early visiting to the child in placement meant that an opportunity was lost to question how negative the lived experience of this child was in reality.

Practice Learning Points – Continuity of Professionals Involved with T

1. Information provided about T on the referral form to the Fostering Team was largely concerned with the reasons for his accommodation rather than with his individual needs. No information was gathered from his mother, who could have provided helpful information about his behaviours, preferences and personality. This meant that the foster carers did not have a full picture of T's needs or a detailed care plan when he was placed.
2. Issues about the care offered by the foster father to children previously placed in the foster home were not explored by social workers, as the foster mother was seen as the main carer. This meant that concerns and complaints from professionals and parents were dealt with on a case by case basis, and not looked at holistically.
3. The structural organisation of Children's Social Care at the time, resulting in a transfer of the case at a number of key practice points, led to a situation where a vulnerable child did not receive consistent supervision from a social worker who had comprehensive knowledge about him as a child in his own right. This can be seen as a systems failure.
4. The Fostering Social Worker was not invited to the Looked After Children (LAC) Review, which immediately followed the Initial Child Protection Conference. As a result of not being invited to the first LAC Review, she was not on the list of professionals to be part of the Family and Professionals meetings which followed.
5. The lack of continuity of professional involvement meant that the foster carers were relied upon to provide information to health and social care professionals pertaining to T's needs, behaviour and presentation. Neither Mother nor the Social Worker were present at the Looked After Child medical to provide any information about T.
6. There was not a single understanding on the part of professionals about the role and responsibilities of the LAC doctor, and she was seen as the clinician responsible for his primary health needs, rather than the GP.
7. An earlier visit by the Children's Guardian to observe T in the foster placement would have enabled direct observation of T's interaction with the foster carers compared to how he interacted with his mother. Children's Guardians should not be reassured that because a foster placement has been approved by a local authority it necessarily meets the needs of vulnerable child/ren placed there.

10. CONSIDERATION OF VIEWS OF FAMILY MEMBERS AND CONNECTED OTHERS

- 10.1 Mother first saw T on 2 April 2013 following his placement with the foster carers. This contact was supervised by a sessional worker and lasted for one and a half hours. Mother described how pleased T was to see her. He put his two arms out, but he was also really upset, crying and clinging to her. We were told that T was an active child when with her, running around and jumping on chairs. This was also confirmed by Maternal Grandmother.
- 10.2 Within a couple of weeks of being with the foster carers, Mother noticed a marked change in T. He would not play with his toys and would scream for chocolate and crisps. At the last contact session Mother was surprised that T put all his toys away. He would often just sit on her lap during contact and Mother said *"He just dropped, he wasn't lively anymore"*. Mother explained how he appeared vacant and said *"If the Social Worker waved her hand in front of his face he would not react."* She also noted a marked decline in his weight, especially when she changed his nappy. Mother described how at one contact session T had a bruise on his forehead which the foster carers told her had occurred when T had 'head butted' the foster father. Mother told us that the foster mother had said that she used to sit T in front of the radiator because he was always cold, especially his hands and feet. A condition, which Mother said T did not have whilst in her care.
- 10.3 When asked whether there was any problem with T eating or vomiting, Mother said this was not the case. T enjoyed his food and she would make him spaghetti bolognaise, fish fingers and chicken, which she would cut up into pieces for him.
- 10.4 Mother told the social worker and her solicitor that something was wrong and that T was a different child since he had been in care. Maternal Grandmother explained that both she and Mother told the social workers of their concerns about the change in T. Their concerns were not acted upon.
- 10.5 Mother spoke movingly of T's last days and described how she knew something was not right when the foster carer locked herself in another room at the hospital, crying hysterically. Mother told Maternal Grandmother that *"I knew she had done something to T"*. Mother described how she had to be supervised by the foster carers' during her visits to T when he was in the PICU, which was the first time she had met them, although she had spoken to the foster mother on the telephone when T was too unwell to attend contact. She described how upset she was when the doctors spoke to the foster carers first instead of her and Maternal Grandmother about T's condition. She said of the foster carers' *"I just wanted them to go so that I could be with T. I just didn't realise how serious it was."*

- 10.6 Mother said that she told the social worker that Maternal Grandmother should have T. She went on to say *“if they’d just listened he would be here still. Social Services should have done their job properly. They didn’t listen to me and my mum [when informed of their concerns]. We think some foster carers are just in it for the money, when they should be there for the children.”*
- 10.7 The Children’s Social Care IMR makes reference to the fact that because T was an emergency admission to care no specific work was undertaken with T or his family, as would have been the case if an initial or core assessment had taken place. This resulted in a lack of early understanding of T’s needs. The report goes on to state that *“during April 2013 the social worker necessarily prioritised work on the accommodation of T but did not subsequently develop a relationship with him.”* Whilst it is accepted that this was the case, the local authority had instigated care proceedings in respect of T, a parenting assessment of Mother and Maternal Grandmother was being considered as a potential carer. Such assessments should have provided plenty of opportunity to explore their view of T prior to and during his placement with the foster carers and for any concerns about changes in his character and presentation to be listened to and investigated. This did not happen, Mother’s concerns were recorded, but no action was taken to follow them up, prior to his death.
- 10.8 Maternal Grandmother was being assessed as a potential carer for T, but as referenced previously in this report, it was her view that the process was taking too long and she was not being taken seriously.
- 10.9 The Lead Reviewers had the opportunity to meet with one of the people who cared for T when he and his mother lived with her and her then partner. She was one of the few people who was able to provide an insight into what T was like as a child, prior to his placement with the foster carers. The information provided has been helpful and informative to the review. The following is an account of what the friend told the Lead Reviewers of her involvement with Mother and T, and Children’s Social Care.
- 10.10 The couple had met Mother again in early April 2013 and she told them that T was in foster care. Mother showed them a photograph of T. The Lead Reviewers were told that T was unrecognisable, as he had lost so much weight. On learning that he was in care, the couple decided that they would like to look after him. They contacted Children’s Social Care to discuss their interest. Despite telephoning and visiting Children’s Social Care offices, the couple were not provided with any information about T, nor were they considered as carers for him. They were told that as Mother had stated that she did not want them involved in looking after T, they could not be assessed.
- 10.11 The couple sought legal advice, applied to the court to be parties to the proceedings, and lodged an application for parental responsibility. They

received confirmation from the court that they could be party to the care proceedings on the day T died.

- 10.12 Because Children's Social Care decided it was not appropriate to consider this couple as connected people, suitable to care for T, several opportunities to influence the outcome of this case were missed. If the couple had been interviewed by Children's Social Care, not only could they have been assessed as possible carers for him, but an insight into T's life could also have been ascertained from two people who knew him very well. In addition, information could have been provided that may have informed the parenting assessment of Mother, which was being undertaken at that time. The decision by the Local Authority not to pursue this couple because Mother opposed their involvement in T's life, removed the possibility of T being placed in the care of people who had known and loved him.
- 10.13 It was particularly unfortunate that the couple were not assessed as potential carers. This is especially so given that the review has learnt that the couple were approved respite foster carers for an independent local fostering agency at the time they were asking to be considered as carers for T. The Lead Reviewers were told that they had looked after a number of children on a respite basis, and had informed Children's Social Care that this was the case when they asked to be assessed as carers for T. There is no record of this information having been documented.
- 10.14 The review has received information that the duty system in place at the time was such that duty calls were filtered by call handlers, who were administrators, and a Practice Leader then decided what was appropriate to pass on to the duty team. It is possible that the couple's initial request to be considered as potential carers for T went through to the duty system. The review has been informed that the system has now changed.
- 10.15 It is concerning that this couple were not interviewed by the Children's Guardian, who told the review, at the practitioners meeting that it was not her responsibility to make contact with or make an assessment of those wishing to be considered as connected people in care proceedings. Clearly the main responsibility for identifying potential alternative carers for a child lies with the Local Authority, but it can be expected that the Guardian would seek to assure herself that the Local authority had carried out this duty within reasonable timeframes. It is unclear how the Guardian had exercised this part of her responsibilities and may be a learning point in Quality Assurance for CAFCASS.
- 10.16 The Review accepts that had the couple been identified as potential carers by the local authority or the Court, then the Guardian would have sought to interview them herself, but the local authority failed to follow up the couple's initial interest. For the Guardian to have interviewed the couple prior to this may well have been seen as inappropriately usurping the role of the local authority.

Practice Learning Points – Consideration of Views of Family Members and Connected Others

1. An earlier visit by the Children's Guardian to observe T in the foster placement would have enabled direct observation of his interaction with the foster carers compared to how he interacted with his mother, although the Review accepts that this is not explicit in Guardian's Practice Directions. Children's Guardians should not be reassured that because a foster placement has been approved by a local authority it necessarily meets the needs of vulnerable child/ren placed there.
2. The concerns of parents and family members about significant, ongoing changes of presentation in a looked after child, need to be listened to, taken seriously and investigated by professionals.

The Legislative Framework concerning 'Connected People'

- 10.17 Given that Warwickshire County Council decided not to consider Mother's friends as potential carers for T, seemingly because of her objections, it is important to consider whether there was any basis in law for such a decision. Regulation 24 of the Care Planning, Placement and Case Review (England) Regulations 2010⁷ which became effective from 1 April 2011, replaced Regulation 38 (2) of the Fostering Services Regulations 2002, which related to immediate placements of children with relatives and friends not previously approved as foster carers.
- 10.18 *"Regulation 24(1) provides that where the local authority is satisfied that an immediate placement with a **Connected** person is the most appropriate placement for the child notwithstanding that the proposed carers are not approved as foster carers, the carers can have temporary approval for a period of up to 16 weeks provided that an assessment of their suitability under Regulation 24(2) has taken place".* It is evident, however, that Children's Social Care's interpretation of this regulation was that consideration needed to be given to people connected to the parent, and not to those connected to the child. This view was confirmed at the practitioners meeting, when Children's Social Care staff commented that they were dependent on the parent to identify the 'connected person.' It was recognised, however, by those attending the meeting that there was a need for social workers to be more proactive in identifying who could be considered as 'connected people', and that there should not be an over reliance on those put forward by birth parents.
- 10.19 The review has been informed that Mother's friends were approved respite foster carers at the time, by a local independent fostering agency.

⁷ http://www.legislation.gov.uk/ukxi/2010/959/pdfs/ukxi_20100959_en.pdf

Whilst Mother's view needed to be taken into consideration as to whether she had any objection to this couple becoming carers for T, the legislation does not state that such objections were paramount in deciding what is in the best interest of a child. Given that Warwickshire County Council had an interim care order in respect of T, then the local authority shared parental responsibility with Mother prior to a Care Order being made. However, the local authority can determine the extent to which they exercise their parental responsibility. If, after assessing the couple a decision was reached that T could be placed with them, the local authority had power to do this and, if this was in the best interests of the child, they had a duty so to place him.

- 10.20 The fact that the couple knew and loved T, that he had lived in their household for almost a year and he knew them, should have been taken into account by the local authority at the earliest opportunity, after they expressed an interest in caring for him. That they had already been approved by a local agency as respite foster carers would have become known to the local authority, and could have been highly significant in that it was a ready reckoner that they were *prima facie* suitable to care for children. They could have been very quickly assessed under the regulations as most of the requirements that needed to be met as to their suitability would have demonstrably already been met by their existing approval as foster carers. The only real issue was whether it was in the best interests of T to be placed with this couple. Unfortunately, the option was not given due consideration as the local authority did not provide an opportunity for them to be assessed as possible carers for T.
- 10.21 The need for Children's Social Care to take into full consideration, appropriately investigate and assess those who are connected to a child, who come forward as carers, is a paramount finding from this Review. It is a lesson learnt and will no doubt resonate with decisions taken in other cases involving the placement of children both in Warwickshire and other local authorities.

Practice Learning Points – Connected People

1. The dismissal of two people who wished to look after T on the basis of Mother stating that she was opposed to their involvement in his care was a misjudged and misinformed decision on the part of the local authority. This was possibly a result of the organisational culture and systems at the time seeing 'connected people' as those being connected to the parent, rather than the child.
2. The responsibility of Children's Social Care to take into full consideration, appropriately investigate and assess those who are connected to a child, who come forward as carers, is a paramount finding from this review.
3. It is the responsibility of the Children's Guardian to ensure that the Local Authority has considered and assessed people close to the child,

and to ensure that all connected people have been appropriately identified. This is a key finding from this Review. It is not the responsibility of the Children's Guardian to assess connected people, but there is a key role to play in ensuring that the local authority has taken appropriate steps to identify those who may be in a position to offer care and support.

11. LOOKED AFTER CHILDREN REVIEW/CHILD PROTECTION PROCESS

- 11.1 The purpose of these meetings was to ensure continuity of the care plan for Looked After Children in between reviews when a Child Protection Plan had ended.
- 11.2 Although the review has been told by IRO1 that the major consideration of the ICPC and the LAC Review was the Police investigation concerning the injuries to T and the parenting assessment of Mother, it is significant that four medical reports concerning T's injuries were not available to be shared at the ICPC. There was no representative from the GP Surgery and the Consultant Paediatrician from Hospital 1 was unable to attend. This was to lead to a reliance on the foster carers providing information to health professionals and social workers of T's health and well-being whilst in their care.
- 11.3 The 'Analysis of Risk' on the Child Protection section of the minutes of the ICPC, reiterates that Dual Status means that Child Protection and Care Planning for T should be integrated. Each agency gave a view and all agreed that T was 'currently safeguarded as he was in Local Authority Care and subject to an Interim Care Order.' Thus, a specific Child Protection plan was not required. Whilst this seems an appropriate decision, the record of this dual meeting remains unclear in that the two processes are not sufficiently separated. There is repetition of recording and discussion without drawing out strong recommendations in the Looked After Child Review section. Specifically, the care plan does not:
- receive detailed consideration;
 - there is no record of timescales for the assessments, and
 - there is no consideration of exploring other adults who had been in T's life as potential carers.
- 11.4 There is no record that the Looked After Children review considered the lack of a placement meeting, and at that stage, the foster placement was considered to be a place of safety for T. However, the lack of a robust care plan, with clear outcomes for the child, which would have required continuity of social work involvement, meant that a holistic assessment was never made of whether the placement met T's needs and promoted

his well-being. This was particularly important, as T was a child placed out of county, and without notification of his transfer to Bossetshire received no input from the Bossetshire Health Visiting Services, the GP or the Named Nurse for Looked After Children.

- 11.5 The Designated LAC Nurse for Warwickshire was not notified that T was placed out of county. This was in breach of statutory guidance as it is a legal requirement⁸ and within local guidance (South Warwickshire NHS Foundation Trust Integrated Care Pathway) for such notification to take place. Information has been provided to the review, following interviews by the South Warwickshire NHS Foundation Trust IMR Author with the Designated Nurse for LAC, that the LAC Health Team are frequently not notified by the local authority when a child is placed into care, despite efforts to obtain the information. Although it is a statutory requirement for relevant professionals to be notified, it would appear as the IMR author comments that “*there is professional acceptance that this does not always happen.*” The lack of sharing such information is significant in this case, and is as relevant for all looked after children placed outside their local authority.

Practice Learning Points – Looked After Children Review/Child Protection Process

1. Arrangements for invitations to dual status meetings are not sufficiently clear and risk missing people who should attend the LAC review.
2. It needs to be clear who is responsible for reviewing the invitation list for review case conferences and statutory reviews so that relevant people are not overlooked because they were not invited to the ICPC.
3. There is a need to ensure that the Designated Nurse for Looked After Children is informed when a child is accommodated, particularly so if the child is placed out of county.

12. FINDINGS/ LESSONS LEARNED

Finding 1: The Sharing of Information

- 12.1 **The sharing of information between professionals is crucial if children are to be safeguarded, and features in the findings of the majority of serious case reviews.** It is extremely pertinent in this case as not only was information withheld by the foster carers, important information was not shared between professionals within the same agency, nor was it always shared on an interagency basis, as highlighted by the lack of information

⁸ HM Statutory Guidance 2009, section 9.4.1

recorded by the Bossetshire LADO Service of referrals made by Warwickshire Children's Social Care.

- 12.2 This, together with a lack of escalation, or indeed proper investigation of the concerns raised by social workers, other professionals, parents, a psychologist and a family court judge, resulted in a missed opportunity to holistically assess the situation as to the safety of this foster placement for vulnerable children.
- 12.3 It is evident from this Serious Case Review that there was a poor understanding of the purpose of LAC health assessments and the role of the Designated Doctor for Looked After Children, as well as the relationship between these functions and the community health services available to children.
- 12.4 There was confusion as to the role of FN2 in this case. She was working with Mother, but was also responsible for health visiting services to T, without being the designated health visitor. The need for professionals to be fully informed and aware of their role and responsibilities, with clear boundaries, when working with looked after children is a finding of this review.
- 12.5 The lack of timely and appropriate information sharing between clinicians and Police when T was admitted to Hospital 2 is a finding of this review. The confusion on the part of the PICU doctor as to which child the CAIU police officer was enquiring about when the unit was contacted has been documented in this report. It is evident from the information provided by Hospital 2 and the Bossetshire Police that by the time T had been admitted to the PICU, non-accidental injury was being considered as a possibility. Whilst definitive scan results and the opinion of expert clinicians were awaited, it was evident that NAI was being taken into account by clinicians. Police should have been informed that this differential diagnosis was being considered earlier on in the process.
- 12.6 This was further compounded by the failure of the EDT social worker in Bossetshire to inform the Bossetshire Police, because of a misunderstanding as to who had statutory responsibility for investigating the circumstances of T's hospital admission. This resulted in Police Officers having to make a number of enquires to ascertain why T was admitted to hospital with a catastrophic brain injury. This in turn meant that the foster carers had unsupervised contact with T during a crucial period, during which time they sought to cast suspicion on his mother, suggesting that his current head injury had resulted from when he was in her care. The need for clear procedures/protocols concerning the timely sharing of information with Police when NAI is suspected, and for all professionals to be conversant with such procedures is a finding, and will be a recommendation from this review.
- 12.7 A further significant finding of the review is that there was a pattern of not sharing information between professionals throughout this case, which sadly contributed to the serious outcome for T. Incidents were seen in isolation

and connections not made, which might have led to questioning of what was happening in the placement. For example, it was accepted that T was possibly incubating chicken pox for a period of a month, which resulted in him not being taken to contact sessions with his mother. This meant that he was not seen by his mother, or indeed any other professional during this period of 'illness'. There was no challenge to the foster carer of why a medical opinion had not been sought, and her word was accepted that T was unwell. It was only Mother who raised the issue of why so many contact sessions were cancelled, which was then brought to the attention of Warwickshire Legal Services and Children's Social Care. Professional overview of this case was lacking and, the pattern of what was essentially, disguised compliance on the part of the foster carers was missed.

Finding 2: Foster Carers as Perpetrators of Abuse

- 12.8 That there were concerns raised by different social workers, parents and other professionals about the foster carers behaviour towards children in their care, has been fully documented in this report. **Although such concerns were raised, they were not escalated through the formal processes related to complaints about foster carers.** This resulted in concerns being recorded on individual children's casefiles, but they were not viewed holistically, until after T's tragic death. Allegations made by children and parents about the behaviour of the foster carers were strongly denied. Although the allegations were noted, they were not robustly investigated and were prematurely closed, without being referred to or appropriately assessed by the LADO. This was a missed opportunity to review the suitability of these foster carers and is a finding of this review.
- 12.9 In discussion with the Named Doctor at Hospital 2, the Lead Reviewer was reminded of the findings of Lord Laming into the death of Victoria Climbié in 2003. Whilst Lord Laming was referring to resistant birth parents, the finding also resonates with the actions and behaviour of the foster carers involved in this serious case review. Lord Laming recognised that social workers faced a *'tough and challenging task'* when working with adults who deliberately exploit the vulnerability of children and who act in devious and menacing ways. *"They will often go to great lengths to hide their activities from those concerned for the well-being of the child.....staff have to balance the rights of a parent with that of the protection of the child."*⁹
- 12.10 It is apparent, albeit, with the benefit of hindsight that the foster carers were creating a picture of a child with special needs, who was difficult to care for and whose catastrophic collapse was due to the previous injuries received whilst in his mother's care.
- 12.11 It is now evident that the foster mother particularly, used the excuse that T may have been incubating chicken pox over a period of a month to ensure

⁹ The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming, 2003

that contact sessions with his family were cancelled. Neither foster carer sought medical advice or attention for T during this time, yet no social worker questioned whether this was appropriate. The reasons as to why such questions were not asked could be linked to the position of trust in which foster carers are held. FN advised the foster mother to take T to the GP, but she ignored this advice, and no action resulted. When it became apparent that T had lost a very significant amount of weight, the foster carer was advised by FN to increase his food portions, but the reason for his weight loss, i.e. his alleged choking when eating, was not questioned or fully explored. It is clear that T was hungry, as evidenced when he sought food from his mother during contact visits. The Serious Case Review into the death of Daniel Pelka reached a difficult conclusion about the work undertaken by professionals who work in the area of safeguarding children. Given the harm experienced by T, it is worthwhile remembering the following statement from the Daniel Pelka review:

“In this case professionals needed to think the unthinkable and to believe and act upon what they saw in front of them, rather than accept parental versions of what was happening at home without robust challenge.”¹⁰

- 12.12 Unfortunately, the professionals who had contact with T, with the exception of Warwickshire EDT Manager 1, had no knowledge of what he was like prior to his placement with the foster carers. His mother and maternal grandmother said on several occasions to social workers (and Mother’s lawyer) that his behaviour had changed and that he was not the same child. Professionals described T as a watchful, quiet, unresponsive and wary child, who had difficulty making eye contact. At the practitioners meeting held as part of this serious case review, SW3 told us that the way he presented was not like anything she had come across before. She was so concerned that she was seeking an expert opinion as to whether his presentation was organic.
- 12.13 That professionals could be so convinced that there was ‘something wrong’ with T and the problem was with him, is an indication of the level of deviousness to which the foster carers resorted to ensure that their neglect and ill treatment of T remained undiscovered, until it was too late.
- 12.14 Although the foster mother attempted to medicalise T, her lack of care and concern for T is apparent from the above, but was especially evident on the day he was critically injured. The foster mother deliberately delayed calling the GP or an ambulance for T for several hours after he was injured and left him alone, in a coma, in his bedroom, whilst she attended to the other children. Although it could be said that the foster mother may have panicked after violently shaking T, which resulted in his critical injury, her refusal to call for immediate medical attention cannot be excused and is indicative of a complete lack of compassion or empathy for a small, vulnerable child.

¹⁰ Coventry LSCB 2013, Serious Case Review Daniel Pelka

- 12.15 Foster carers are in a position of trust, and the majority of foster carers respect that trust and provide excellent care to children. Professionals do not expect children to be harmed, neglected or ill-treated whilst being looked after by foster carers. It is therefore difficult for professionals to consider the possibility that a child in a foster placement might be deliberately neglected or harmed. It is apparent, however, especially given recent disclosures of historical abuse by children previously looked after, that social workers need to maintain respectful uncertainty where concerns arise about the care offered to a looked after child, or where there is an obvious deterioration in the health, behaviour and presentation of a child. The need to share and act on those concerns is of paramount importance if children are to be protected and is a finding of this review.
- 12.16 This Serious Case Review has highlighted the importance for all partner agencies to be made aware of the need for respectful uncertainty on the part of professionals in their involvement with foster carers where concerns arise about a child's presentation, behaviour and health needs.

Finding 3a: The supervision and quality assurance systems within Fostering services, and the monitoring of placements

- 12.17 **The importance of consistency of social worker allocation and their supervision cannot be over stated in this case, and was an issue in both the Fostering and Children's Social Work Teams.** In respect of the Fostering Team, historical concerns about the foster carers were not known by the social worker supervising the foster home during T's placement. The importance of reading and understanding the whole of a child's file has been particularly highlighted by this case. There was evidence of good and appropriate use of supervision to discuss Fostering SW1's growing concerns about the foster carers, but no evidence of how this was followed up, and particularly no evidence of this being shared with the child's social worker. It was apparent from the reports and practitioners' meetings that the social workers in the Fostering Team did not read the previous records, so although social workers do change and organisationally this can be difficult to address, the impact would have been mitigated if the records had been thoroughly read and the history understood. This applies to both Fostering and Children's Social Work Teams.
- 12.18 Organisationally there was little evidence of a culture of information being shared between Children's and Fostering Teams, including "soft" information where concerns were beginning to mount. This in part supported the organisational culture of workers and managers taking on board comments and views about people and situations made without substantial evidence, and then not re checking back to the source. An example of this is the discrepancy between how the foster carers described T and how his mother described him. The implications for this were not scrutinised. This was particularly apparent during the practitioners meeting, when some people were still clearly struggling to accept the degree of the foster carers' culpability in T's ill treatment and death whilst in their care. Views developed early on with little firm evidence were held without professional interrogation

or curiosity. This has of course been seen in a number of Serious Case Reviews nationally.

- 12.19 There is also a finding from this Review about the impact of the quality of information going to the Fostering Panel on the subsequent recommendations, and the lack of follow through of actions when these are recommended by Panels. Panels are only able to make a judgement and recommendations based on the information put in front of them, and the review has found that the Fostering Panel did not have all the information required to make sound recommendations.
- 12.20 Organisationally there is an issue about the quality assurance of both social work reports and the Panel functioning. The Fostering Assessment provided to the Serious Case Review was procedurally compliant and at that stage there was no evidence that the foster carers would not be able to care safely for young children. The issue here is the lack of consistency in identifying and bringing growing concerns to the Performance Reviews. If the concerns had been reported as complaints, as has been considered earlier, they would have been included in the summary for the fostering reviews. However, there was no scope for discussion about the foster carers overall coping capacity within the system of Practice Leaders taking reviews to the Panel on behalf of social workers, when they did not have personal knowledge and involvement with the foster carers. This is an example of a good idea about saving resources of time, which in fact was not fully thought through. It was functional in processing reviews but the quality was affected.
- 12.21 It is apparent that there was a significant period where the foster carers received no supervision from the Fostering Service, which was unacceptable, and which could not only have led to children being placed at risk, but also left the foster carers vulnerable and unsupported. It is apparent that the focus of the Fostering Service has been on supporting foster carers rather than scrutinising their day to day practice as carers for children with often complex problems. Thus, these carers who were perceived as being experienced, would not have been seen as a priority for allocation in the absence of their permanent worker.

Finding 3b: The implementation and monitoring of care and placement plans

- 12.22 **Consistency of social work involvement in a case is crucial if a comprehensive picture is to be built of a child's needs.** This is particularly relevant to this review, given that three different social workers had responsibility for T at different times during his three-month period in care. This was due to the way in which the system was structured to accommodate the allocation of cases, which resulted in a situation where none of the social workers allocated to T had time to develop a relationship with him and get to know him as a child in his own right. The Lead Reviewers were told by SW3, at the practitioners meeting that her main focus was on the preparation of the case for care proceedings, not on the placement.

- 12.23 The process in place was procedurally correct, in that this social worker was receiving close supervision from an experienced Practice Leader, but the process did not apparently support the Practice Leader in doing anything which allowed her to triangulate the reporting of the worker, for instance by visiting the child herself and familiarising herself with the background. This was not in practice a co-worked case and the social worker was allocated a complex and serious child protection case without the support she needed. At this stage in practice development the worker, like others in this case, was taking reporting from the foster carers at face value and thus formed a view of T based on their reporting. In parallel to this, the Practice Leader also accepted the view of the social worker. There was little evidence of communication between the Children's Team and the Fostering Team, which might have offered a different view of the placement. The role of the Family Nurse Practitioner as we have already seen, was similarly not fully used to triangulate what was actually happening in the household, as so little information was shared.
- 12.24 Given the concerns raised by the Fostering SW1 about the placement before T was placed as an emergency, a placement review should have taken place on her immediate return from leave. This did not happen.
- 12.25 The LAC review raises concerns about whether it sufficiently addressed T's needs and promoted his wellbeing. The care plan did not receive detailed consideration at the review; there was no record of timescales for assessments and there was no consideration given to exploring other adults in T's life as potential carers. It is the responsibility of Children's Social Care to consider whether there were any connected people who might be potential carers. The review accepts that it is not the role of either the Children's Guardian or the IRO to assess adults in a child's life as potential carers, but it is part of their responsibilities to ensure that questions are asked to draw out who may be relevant in a child's life. In this case it is evident this did not happen and it is a failure of Quality Assurance specifically for the Independent Reviewing service that this gap in understanding of the role was not picked up.
- 12.26 The dual status of the ICPC and LAC review did not appear to support the opportunity of looking in detail at the day to day experience of T in his placement, as the main focus was on the child protection element. A specific LAC review would more likely to have been held in the foster carers home, and would have probably allowed for more reflection on T's presentation, his medical and developmental needs and his day to day routine. This might well have allowed more free discussion and involvement from Mother and thus a reflection on his changed presentation and demeanour. The focus on risk and forward planning of the dual status review rather than what was happening here and now for T assisted in the foster carers' manipulation of the view of T.
- 12.27 This Serious Case Review has found that there was an absence of a constructive care plan which took into account all possible care options for T,

his best interests and his wellbeing. The concerns expressed by his mother and maternal grandmother about the deterioration in his presentation and demeanour, (especially given that T was a child with limited vocabulary) were not given appropriate importance. There is a stark contrast between the response to the foster carers providing information to that of Mother reporting changes in T's presentation. The need for professionals to listen to and take account of the concerns voiced by parents and family members about detrimental changes in a looked after child, is one of the paramount findings of this review. This review has highlighted that the perceived status of an individual communicating information makes a difference as to the way in which professionals respond. The need for LAC plans and reviews to be subject to a process of robust Quality Assurance is a finding and will be a recommendation arising from this review.

- 12.28 It was apparent that the role of the Community Paediatrician and the function of LAC Health Assessments was not clearly understood by all those involved in this case, and there was an inconsistent view. This led to confusion about who was responsible for following up day to day concerns about T's health and development, and specifically undermined the role of the local GP and Health Visitor. Too much reliance was placed on the Health Assessment picking up and progressing concerns about this child. There was also no transparent process in place for the distribution of reports before and following a Health Assessment and this had a serious impact in this case.

Finding 4: Connected People

- 12.29 The need for professionals to give serious consideration to connected people, who wish to care for a child is an important finding of this review. Professionals from all agencies need to focus on the connection of people to the child and not their connection to the parent.

13. CONCLUSION

- 13.1 The first public inquiry into the death of a child in foster care was the Monkton Inquiry which opened in April 1945 following the brutal murder of a 13 year old boy, Dennis O'Neil, by his foster father. The findings of the Inquiry were to lead to the passing of the Children Act 1948, which placed an emphasis on keeping children with birth parents, wherever possible. Although the circumstances of Dennis O'Neil's murder were different to those leading to the death of T, some of the findings from that Inquiry are pertinent to this Serious Case Review, and to the many other reviews and public inquiries which have followed, namely:

"The issues that contributed to his death – poor record-keeping and filing, unsuitable appointments, lack of partnership working, resource concerns, failing to act on warning signs, weak supervision and "a lamentable failure of communication" – were not buried with Dennis O'Neill. These failings were to feature regularly in inquiries held into the death or abuse of children in care

for the next 60 years – up to and including that of eight-year-old Victoria Climbié”¹¹.

- 13.2 It is seriously concerning that the issues which contributed to the death of a child over 70 years ago are still prevalent today. The need for professionals to maintain professional curiosity, and respectful uncertainty where concerns arise about the care offered to children whether by birth parents or foster carers cannot be overemphasised. There were sufficient concerns to question the motivation and the suitability of these foster carers to look after children. If information about such concerns had been appropriately shared and investigated, then questions as to the suitability of the foster carers may have been more robustly considered. Similarly, serious consideration should have been given to others who came forward to care for T. If such scrutiny had occurred, then T’s death may have been prevented.

14. RECOMMENDATIONS FOR CONSIDERATION BY WARWICKSHIRE LSCB

1. The Board should consider whether partner agencies are giving sufficient scrutiny and importance to the safeguarding of children looked after. Specifically, actions need to be in place to ensure that it is well understood that at times children are harmed by carers and other professionals, and this can include foster carers. There cannot be a presumption that all children in placements are safe at all times, and training and briefings on issues arising from this Serious Case Review should address this.
2. It is important that the tensions between the County Council’s responsibilities for ensuring sufficiency of placements and maintaining the quality assurance of fostering placements are well understood and held in balance. Lessons from the process of quality assurance for externally contracted placements may be useful.
3. The Board will want to reassure itself that a review carried out into the Fostering Service has addressed the following issues:
 - Is information from other services shared and considered by Fostering Panels?
 - How robustly cases are presented to Panels and by whom?
 - Has the Fostering Service improved since it has become a countywide service, and have the recommendations of the Fostering Review Action Plan been put into place, including the new role of Quality Assurance Officer?
 - Is there a robust Quality Assurance system in place for ensuring that professional curiosity and scrutiny are maintained in the process of decision making for approving foster carers, and for the continual supervision of placements?

¹¹ <http://www.communitycare.co.uk/2007/01/10/what-have-we-learned-child-death-scandals-since-1944/>

- Are concerns/complaints about foster carers being recorded on the fostering file, and appropriate action taken where required?
 - Are arrangements in place for restricting the type of placements made in individual fostering households, on the basis of professional assessment and review, rather than with emphasis on the carers' preferences alone?
 - Are the communication links between Fostering and other teams, including Children's Social Work Teams sufficiently robust to ensure that concerns from all professionals and people relevant to a child in care are given weight and shared appropriately?
 - Are appropriate processes in place to ensure that when information is requested from GPs during assessments for fostering the detail needed is clear and transparent?
4. The Board needs to be assured that the role and function of the LADO is understood by all agencies, and that there is a robust system in place to ensure that concerns about those in a position of trust are appropriately managed.
 5. Where social workers and partner agencies have concerns about the care offered by foster carers they are made aware of the need to formally register such concerns as complaints to be investigated. Such complaints which concern allegations against foster carers and their position of trust need to be brought to the immediate attention of the LADO. Clarity is required as to cross border LADO arrangements for investigating allegations brought against foster carers employed by one local authority, but who reside in another.
 6. Professionals, including medical staff should not wait until a definite diagnosis is in place before making child protection referrals. This recommendation is made in light of the fact that hospital staff appeared to have waited almost 24 hours before raising child protection concerns in respect of T, while investigations as to whether he had an organic illness or had suffered trauma took place. During this time there was confusion about contact and parental responsibility. It is of note that he did receive excellent medical care. Warwickshire and Bossetshire LSCBs need to ensure professionals are reminded that the threshold for making a child protection referral is *'reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm'*¹².
 7. Multi-agency staff need to be clear about whether they are notifying Social Care colleagues about a looked after child who is in hospital; or whether they are making a child protection referral in respect of a suspicion of non-accidental injury to a child who is also looked after, and a Section 47 investigation is required.
 8. When a Looked After Child is placed out of area this adds to the complexity of a case, and will require communication with more than one Local Authority.

¹² The Children Act 1989

The fact that a child may still be geographically close to their Local Authority of origin must not cloud the issue of the need for careful information sharing across borders. There have been changes to the structure and management of out of hours services for child protection in the area relevant to this review and it is appropriate for the Board to ensure that the lessons from this case are now well understood.

9. The Board needs reassurance that measures are in place to ensure that Children's Social Care and Health professionals are clear about the function of a Looked After Child (LAC) Health Assessment, and the role of the Community Paediatrician who undertakes such assessments, in comparison to other clinicians and Health Services provided to a child.
10. The role of the Family Nurse Practitioner needs to be clarified specifically where children are in foster care. The support a foster carer may require in caring for a child, needs to be addressed separately from the overview of day to day child health and development, which would normally be monitored by a Health Visitor attached to the child's registered GP. There appeared to be a disconnect between the FNP and local community health services in this case, which left a child vulnerable, with an overreliance on the account of the foster carers rather than on accurate observation and knowledge of this child. In addition, the FNP programme needs to review their processes to ensure that an effective health provision is in place when an FNP programme is being delivered across a border into an area where it is not provided.
11. The findings of this review are disseminated to all partner agencies, to Bossetshire Safeguarding Children Board and the judiciary involved in the care proceedings case of the foster carers' children for the promotion of learning and reflection.

APPENDIX 1

Summary of Practice Learning

1. There was limited exploration of some aspects of the foster carers' lives and of the effect these may have on their relationship.
2. Whilst there was recording of the fostering assessment, annual reviews and contact with the foster carers, there was a lack of critical appraisal of their skills, and gaps in supervision at key points, by the fostering social worker. It is important to recognise that the role of the fostering social worker is to take into account not only the needs of the foster carers, but most importantly the needs and wellbeing of the child in the placement.
3. The need for regular and consistent supervision of foster placements is crucial for the safeguarding of children, especially nonverbal/pre-school children. In this case the foster carers were without the oversight and support of a Fostering Social Worker for ten months. The onus was on the foster carers to bring any issues to the attention of the Fostering Duty Social Worker or for the Children's Team Social Worker/s to report any concerns about the care of the children in placement. This was a clear breach of regulations and did not support continuity of understanding and monitoring of this household.
4. There was seemingly no challenge from the Fostering Panel as to the accuracy of the information presented, given the limited contact the Fostering Team had with the foster carers during this period. The overall lack of robustness in the annual reviews was thus a lost opportunity to begin to collect concerns and alert practitioners. Both social workers and the Fostering Panel need to consider and question whether information is missing or unavailable, when reports are prepared and when they are presented.
5. There was a lack of recognition by fostering social workers of the gaps in the knowledge and understanding of child development and attachment theory on the part of the foster carers. This was evident in the unrealistic expectations the foster father clearly expressed about T. The need to robustly challenge such views and to ensure that suitable training is made available to and taken up by foster carers is an important finding of this review.
6. The need to share information between teams within a local authority cannot be overemphasised. The sharing of important information did not happen in this case. There is now in place the means for such information to be readily accessed electronically by all social care practitioners working with looked after children. It is anticipated that the findings of this review will enhance and strengthen the use of this facility.
7. There were concerns from very early on in the foster carers fostering career. However, there was a lack of rigorous monitoring of their development skills as carers, and too little communication between those professionals who had knowledge of the household. Essentially these were safeguarding concerns.

8. Concerns were not followed up, as expected by the fostering regulations, and neither were they fully considered in the context of child protection.
9. If concerns about the placement had been reviewed and assessed, it would have revealed that:
 - a) the foster carers had difficulty meeting the needs of children unless they were very straight forward;
 - b) they struggled with placements where the child had learning difficulties and where children had attachment issues. Indeed, they showed very little understanding of attachment theory and the link between child development;
 - c) they found it difficult to work with parents, particularly in relation to contact;
 - d) at times there were indications the foster carers were under financial stress, but the impact of this on their capabilities as foster carers does not seem to have been understood or explored.
10. Over the four years of fostering children, the couple experienced difficulties working with several parents of children placed with them. In all, there were 7 concerns raised about their care of children. In turn, they made complaints about professionals and at times threatened and subsequently gave notice for children in their care to be removed when the placement became too difficult for them to manage. These issues were not viewed from a holistic perspective by professionals supervising the placement, which enabled the foster carers to continue to have vulnerable children placed in their care.
11. Only one of the concerns or allegations raised about the foster carers were escalated to the LADO in either Warwickshire or Bossetshire. Whether this was because there was a lack of awareness of the procedure and criteria for making a referral is not known. However, it is apparent from the practitioners' meetings set up to inform this review that there continues to be a lack of awareness across agencies in Warwickshire as to the function of the LADO. A number of practitioners attending the meeting were unaware of the LADO's role or the criteria for making a referral.
12. Where concerns arise about the approval category of a foster carer, i.e. the number and age of children placed, such information needs to be incorporated into fostering reviews.
13. A system which relies on Practice Leaders presenting cases, for which they have no direct responsibility, can lead to important information not being presented to the Fostering Panel.
14. There was little seeming awareness on the part of those professionals working with the foster carers of the requirement to consider the welfare of the children in their care from a safeguarding perspective.
15. The importance of formally recording decisions/recommendations in fostering reviews and with the Fostering Panel about the appropriateness of the placement of children with foster carers is crucial if tragedies such as occurred in this case are to be avoided. Such information needs to be easily accessible to placing social workers and needs to be flagged on the database of available foster placements.

16. There is a need to take into consideration the closeness in age of children already in a home when placing any child, including when in emergency circumstances. Where such placements cannot be avoided the need to review the appropriateness of the decision made as soon as possible is of the utmost importance to maintain the welfare of the child. No such review took place in this case when the supervising fostering social worker returned from leave and undertook responsibility for the placement.
17. No social worker accompanied T to the foster home, as he was taken from hospital to the office by a duty social worker and then collected by the foster mother, who took him home. This did not comply with placement regulations and was not good practice.
18. When a child is admitted to foster care, it is best practice for a placement meeting to take place, within 5 working days, at the foster home, to draft a placement plan, with the foster carer/s, the child's social worker, the fostering social worker and the child's birth parent (if no risk is presented by the birth parent to the placement) to be present. This did not occur in this case, as the placement plan was drafted in the Children's Social Care office. This was a lost opportunity to compare how T was at that time before he was placed the foster home.
19. There were indicators that the foster carers were under some financial pressure, however, this was not fully explored or monitored by those supervising the placement. Financial difficulties are not necessarily an indicator of a safeguarding concern in a foster placement, however it was of particular significance in this case as their difficult financial circumstances proved to be a key part of the couple's motivation to foster children. Information provided about T on the referral form to the Fostering Team was largely concerned with the reasons for his accommodation rather than with his individual needs. No information was gathered from his mother, who could have provided helpful information about his behaviours, preferences and personality. This meant that the foster carers did not have a full picture of T's needs or a detailed care plan when he was placed.
20. Issues about the care offered by the foster father to children previously placed in the foster home were not explored by social workers, as the foster mother was seen as the main carer. This meant that concerns and complaints from professionals and parents were dealt with on a case by case basis, and not looked at holistically.
21. The structural organisation of Children's Social Care at the time, resulting in the transfer of the case at a number of key practice points, led to a situation where a vulnerable child did not receive consistent supervision from a social worker who had comprehensive knowledge about him as a child in his own right. This can be seen as a systems failure.
22. The Fostering Social Worker was not invited to the Looked After Children (LAC) Review, which immediately followed the Initial Child Protection Conference. As a result of not being invited to the first LAC Review, she was not on the list of professionals to be part of the Family and Professionals meetings which followed.

23. The lack of continuity of professional involvement meant that the foster carers were relied upon to provide information to health and social care professionals pertaining to T's needs, behaviour and presentation. Neither Mother nor the Social Worker were present at the Looked After Child medical to provide any information about T.
24. There was not a single understanding on the part of professionals about the role and responsibilities of the LAC doctor, and she was seen as the clinician responsible for his primary health needs, rather the GP.
25. An earlier visit by the Children's Guardian to observe T in the foster placement would have enabled direct observation of his interaction with the foster carers compared to how he interacted with his mother, although the Review accepts that this is not explicit in Guardian's Practice Directions. Children's Guardians should not be reassured that because a foster placement has been approved by a local authority it necessarily meets the needs of vulnerable child/ren placed there.
26. The concerns of parents and family members about significant, ongoing changes of presentation in a looked after child, need to be listened to, taken seriously and investigated by professionals. The dismissal of two people who wished to look after T on the basis of Mother stating that she was opposed to their involvement in his care was a misjudged and misinformed decision on the part of the local authority. This was possibly a result of the organisational culture and systems at the time seeing 'connected people' as those being connected to the parent, rather than the child.
27. The responsibility of Children's Social Care to take into full consideration, appropriately investigate and assess those who are connected to a child, who come forward as carers, is a paramount finding from this review.
28. It is the responsibility of the Children's Guardian to ensure that the Local Authority has considered and assessed people close to the child, and to ensure that all connected people have been appropriately identified. This is a key finding from this Review. It is not the responsibility of the Children's Guardian to assess connected people, but there is a key role to play in ensuring that the local authority has taken appropriate steps to identify those who may be in a position to offer care and support.
29. Arrangements for invitations to dual status meetings are not sufficiently clear and risk missing people who should attend the LAC review.
30. It also needs to be clear who is responsible for reviewing the invitation list for review case conferences and statutory reviews so that relevant people are not overlooked because they were not invited to the ICPC.
31. There is a need to ensure that the Designated Nurse for Looked After Children is informed when a child is accommodated, particularly so if the child is placed out of county.

WSCB Response to Child T SCR report

WSCB accepts the findings and recommendations of this important serious case review. As a Board we recognise the extremely distressing nature of this case, in which a vulnerable young child was killed while in the care of foster carers with whom he had been placed for his own safety and protection. We would wish to offer our condolences to the child's mother and all those who knew and loved this child.

The death of a child in such circumstances is fortunately rare, but our aim is to reduce the possibility of a similar event happening again to the lowest possible level. The Board wishes to take this opportunity to look carefully at our systems and processes in order that we can improve these and minimise the risks to other children.

As a result of the criminal process following T's death, the Serious Case Review was underway for over three years. Learning that was identified during the process was responded to immediately, consequently a great deal of work has already taken place to address some issues. Other learning became clear later in the process, and work on these issues is at an earlier stage. A detailed plan has been produced setting out this work.

A summary is presented here of the actions taken and planned in response to the recommendations.

Recommendation 1: The Board should consider whether partner agencies are giving sufficient scrutiny and importance to the safeguarding of children looked after. Specifically, actions need to be in place to ensure that it is well understood that at times children are harmed by carers and other professionals, and this can include foster carers. There cannot be a presumption that all children in placements are safe at all times, and training and briefings on issues arising from this Serious Case Review should address this.

The theme of the WSCB 2016 Conference was 'professional curiosity and respectful uncertainty'. This was used as an opportunity to reinforce the need for all professionals to notice things that don't seem quite right and take steps to explore them. A 'learning from reviews' one page handoutⁱ specifically mentions that this should include remembering that professionals may also sometimes harm children.

Another WSCB review completed in 2014 identified the need for work to be done to improve the system for making and receiving notifications to LAs and looked after children health teams about children placed out of area, or placed in Warwickshire by other LAs, and this work is complete. The review also triggered work to strengthen relationships between Warwickshire agencies and independent children's

homes in the County. WSCB has requested performance reports from relevant agencies to test the effectiveness of the revised arrangements

WSCB has considered the Annual Report of the Independent Reviewing Service by the County Council , and will shortly be receiving the Annual Report of the LADO (Local Authority Designated Officer) from the County Council.

WSCB is requesting reports from all partner agencies to ask what they know about looked after children receiving services from them. This information is already being requested from schools in a new schools' safeguarding audit implemented this year.

The County Council will invite a peer review of services for looked after children, and WSCB will take a report from WCC on the outcome and actions arising from this. The Council will also be arranging for training and briefings for staff and the Fostering panel; and will consider how to extend briefings to external fostering agencies.

Several steps are being taken to improve the scrutiny function of panels, and to strengthen their role in approving what type of placements carers will be approved for.

A placement hub was opened in October 2016, which is providing a better structure for placement referral and matching processes.

Recommendation 2. It is important that the tensions between the County Council's responsibilities for ensuring sufficiency of placements and maintaining the quality assurance of fostering placements are well understood and held in balance. Lessons from the process of quality assurance for externally contracted placements may be useful.

The County Council continues to work to meet its sufficiency duty.

Processes for undertaking foster carer review have been strengthened at a number of points in the process, including using chronologies to examine a full history, better access to 'soft' information in the database and improved quality assurance of the material that is presented to panel

Recommendation 3. The Board will want to reassure itself that a review carried out into the Fostering Service has addressed the following issues:

- **Is information from other services shared and considered by Fostering Panels?**
- **How robustly cases are presented to Panels and by whom?**

- **Has the Fostering Service improved since it has become a countywide service, and have the recommendations of the Fostering Review Action Plan been put into place, including the new role of Quality Assurance Officer?**
- **Is there a robust Quality Assurance system in place for ensuring that professional curiosity and scrutiny are maintained in the process of decision making for approving foster carers, and for the continual supervision of placements?**
- **Are concerns/complaints about foster carers being recorded on the fostering file, and appropriate action taken where required?**
- **Are arrangements in place for restricting the type of placements made in individual fostering households, on the basis of professional assessment and review, rather than with emphasis on the carers' preferences alone?**
- **Are the communication links between Fostering and other teams, including Children's Social Work Teams sufficiently robust to ensure that concerns from all professionals and people relevant to a child in care are given weight and shared appropriately?**
- **Are appropriate processes in place to ensure that when information is requested from GPs during carers' assessments including foster carer assessmentss the detail needed is clear and transparent?**

The County Council has provided WSCB with information about changes that have been made across the relevant services to improve the coherence of record keeping, increase the rigour and oversight of assessments and strengthen the scrutiny function of panels. A full Foster Care Service Review has been undertaken that has made recommendations for service improvements including the format and processes for transferring foster carers between workers.

WSCB welcomes the County Council decision to request a peer review which provides an opportunity to identify any further improvements which can be made to strengthen safeguarding arrangements in the service.

Steps have been taken to improve the communication with GPs with greater clarity in the requests for information to inform assessment of foster carers, and increased use of direct communication.

Recommendation 4. The Board needs to be assured that the role and function of the LADO is understood by all agencies, and that there is a robust system in place to ensure that concerns about those in a position of trust are appropriately managed.

The arrangements for making referrals about allegations against people in a position of trust have been brought into the MASH to provide better support to the LADOs,

and to create better clarity about the respective roles of the LADO and the children's social work teams. The interagency procedure is being updated to reflect this, and WSCB will be offering training on using the procedures, delivered by the LADO.

WSCB has asked all partner agencies to report on the arrangements in their agency to deal with concerns about staff in a position of trust, and how these arrangements are communicated throughout the organisation.

The County Council has raised the issue of different LADO practice from region to region with the National LADO network.

Recommendation 5. Where social workers and partner agencies have concerns about the care offered by foster carers they are made aware of the need to formally register such concerns as complaints to be investigated. Such complaints which concern allegations against foster carers and their position of trust need to be brought to the immediate attention of the LADO. Clarity is required as to cross border LADO arrangements for investigating allegations brought against foster carers employed by one local authority, but who reside in another.

Guidance for social workers who work with foster carers and fostered children has been issued, defining complaints, causes for concern and allegations, and how each of these should be responded to.

The discrepancies found in the the review between the management of 'position of trust' referrals in the East and West Midlands has been notified to the Chair of the National LADO network by the Warwickshire DCS, and this group has agreed to develop a guideline for use nationally. In the interim, a local agreement has been made between Warwickshire and Bossetshire that when a LADO is consulted about a case with a crossborder component they will liaise directly with their counterparts in the other area to reach agreement about which of them is overseeing the specific case.

The Warwickshire LADO is now taking referrals through the MASH. This is providing the LADO with increased capacity and timely access to all relevant information held by other agencies in Warwickshire.

Recommendation 6. Professionals, including medical staff should not wait until a definite diagnosis is in place before making child protection referrals. This recommendation is made in light of the fact that hospital staff appeared to have waited almost 24 hours before raising child protection concerns in respect of T, while investigations as to whether he had an organic illness or had suffered trauma took place. During this time there was confusion about contact and parental responsibility. It is of note that he did receive excellent medical care. Warwickshire and Bossetshire LSCBs need to ensure professionals are reminded that the threshold for making a child protection

referral is ‘reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm.’

Briefings on the learning from this SCR will include reminding all staff that the threshold for referring child protection concerns is ‘reasonable suspicion’ of significant harm.

A small working group lead by the designated nurse and doctor will look at the LIPP briefingⁱⁱ about interpreting medical information in possible child protection contexts with a view to selecting suitable tools to adopt in Warwickshire.

Recommendation 7. Multi-agency staff need to be clear about whether they are notifying Social Care colleagues about a looked after child who is in hospital; or whether they are making a child protection referral in respect of a suspicion of non-accidental injury to a child who is also looked after, and a Section 47 investigation is required.

A briefing noteⁱⁱⁱ explaining the issue and what action is required has been circulated to all partner agencies, and board members have been asked to report on how this has been disseminated to frontline staff.

Recommendation 8. When a Looked After Child is placed out of area this adds to the complexity of a case, and will require communication with more than one Local Authority. The fact that a child may still be geographically close to their Local Authority of origin must not cloud the issue of the need for careful information sharing across borders. There have been changes to the structure and management of out of hours services for child protection in the area relevant to this review and it is appropriate for the Board to ensure that the lessons from this case are now well understood.

The work referred to above has strengthened arrangements for notifying agencies in the host area about placement of Warwickshire children, and this will be further enhanced when the placement hub opens.

Recommendation 9. The Board needs reassurance that measures are in place to ensure that Children’s Social Care and Health professionals are clear about the function of a Looked After Child (LAC) Health Assessment, and the role of the Community Paediatrician who undertakes such assessments, in comparison to other clinicians and Health Services provided to children.

The SWFT Integrated Care Pathway is a joint agreement relating to services for children in the care of Warwickshire County Council, between South Warwickshire Foundation Trust, the County Council and COMPASS (who provide school nursing in Warwickshire). It is reviewed annually, and the updated document clearly details the purpose of looked after health assessments, and the role of the community paediatricians undertaking them, and states that any health concerns must be shared with the GP by health and social care staff for on-going review and actions.

A range of approaches have been taken to ensure that all relevant staff are familiar with this document, and know where to access it, including supervision and single and multi-agency training. This includes health visitors, family nurses and social workers.

Recommendation 10. The role of the Family Nurse Practitioner needs to be clarified specifically where children are in foster care. The support a foster carer may require in caring for a child, needs to be addressed separately from the overview of day to day child health and development, which would normally be monitored by a Health Visitor attached to the child's registered GP. There appeared to be a disconnect between the FNP and local community health services in this case, which left a child vulnerable, with an overreliance on the account of the foster carers rather than on accurate observation and knowledge of this child. In addition, the FNP programme needs to review their processes to ensure that an effective health provision is in place when an FNP programme is being delivered across a border into an area where it is not provided.

During the delivery of the FNPP to a child who becomes looked after by the Local Authority after enrolment onto the programme, the Family Nurses continue to deliver the Healthy Child Programme (DH), to the subject child/ren. This would include liaison with internal and external services and agencies, including General Practice. This is in addition to the work they would do with the child's mother as part of the FNPP. The aim is to provide continuity of care.

Decisions to continue the delivery of the programme are made on an individual case by case basis. Supervision provided by the Family Nurse Supervisor and Named Nurse for Safeguarding Children enable discussions regarding decision making. The FNPP National Unit advises that processes are to be agreed locally.

SWFT FNPP acknowledges that there is a need to review current practice through the FNP advisory board to strengthen communication pathways with universal health services for children who are Looked After.

The Family Nurse Partnership National Unit advises that arrangements for service delivery across county borders are to be determined by local agreements.

At the time the FNP programme (FNPP) was being delivered to Child T, SWFT FNPP maintained the service provision when clients transferred out into neighbouring counties where the FNPP was not commissioned.

Since this time the national coverage of the FNPP has increased resulting in most of Warwickshire's neighbouring counties now providing the programme. It has become less of a requirement therefore to deliver the FNPP outside of Warwickshire's boundaries. Currently however some areas have decommissioned the programme. Learning from this Serious Case Review the SWFT FNPP no longer maintains

clients on the programme once they have moved outside of Warwickshire borders. Recent case examples demonstrate this.

SWFT FNPP will request that the FNPP National Unit share the learning from this case and highlight the risk for other programmes for cross border arrangements.

ⁱ apps.warwickshire.gov.uk/api/documents/WCCC-850-599

ⁱⁱ <http://www.scie.org.uk/children/safeguarding/case-reviews/learning-from-case-reviews/07.asp>

ⁱⁱⁱ apps.warwickshire.gov.uk/api/documents/WCCC-850-598