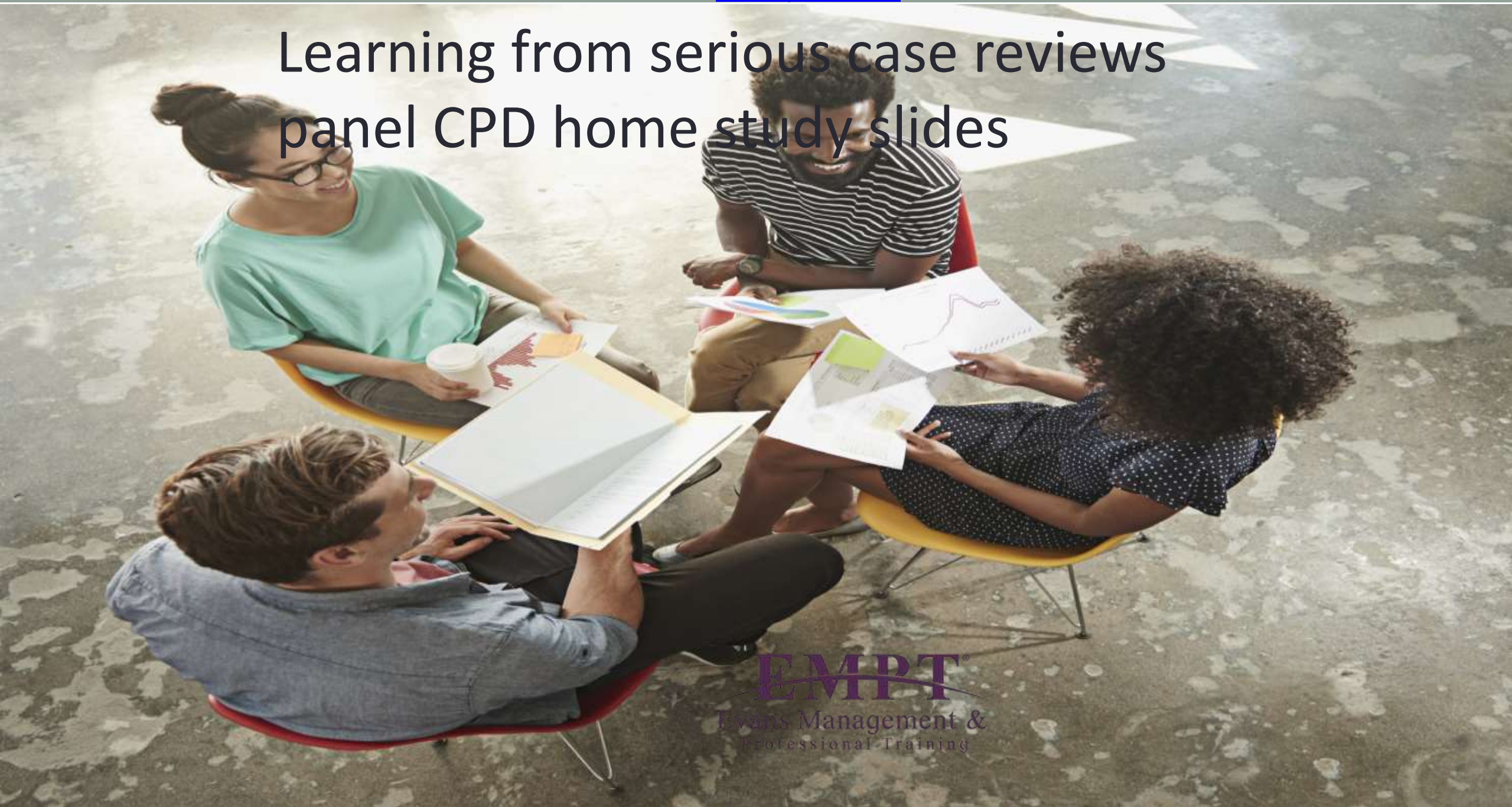
Learning from serious case reviews panel CPD home study slides



Outcome (1)

1. Know about serious case reviews and examine ways the fostering panel practice can be improved following examining such reviews

1.1: define a serious case review

1.2: outline how practice can be improved following learning from the facts from some serious case reviews

1.3 identify actions panel members can take following reflection on serious case reviews

NOTE!

- NEW PANEL MEMBERS ARE EXPECTED TO HAVE REFLECTED ON THESE COURSE MATERIALS VIA THEIR EVALUATION FORM STAFF TRAINING AND SHOULD HAVE OBSERVED A PANEL BEFORE THEY FORMERLY CONTRIBUTE TO STATUTORY PANEL DISCUSSIONS. THE PANEL CHAIR/VICE CHAIR WILL THEN FORMERLY CONSIDER YOU AS AN AVAILABLE CENTRAL LIST MEMBER.

NMS 23 (PANEL CENTRAL LIST MEMBERS TRAINING AND DEVELOPMENT EXPECTATIONS)

- 23.9) Each person on the central list is given induction training which is completed within 10 weeks of joining the central list.
- 23.10) Each person on the central list is given the opportunity of attending an annual joint training day with the fostering service's fostering staff.
- 23.11) Each person on the central list has access to appropriate training and skills development and is kept abreast of relevant changes to legislation and guidance.

Regulation 24.—(1) No business may be conducted by a fostering panel unless at least the following meet as the panel—

- (i) either the **person appointed to chair** the panel **or one of the vice chairs,**
- (ii) one member who is **a social worker** who has at least three years' relevant post-qualifying experience, and
- (iii) **three**, or in the case of a fostering panel established under regulation 23(5) four, **other members**, and
- where the chair is not present and the vice chair who is present is not independent of the fostering service provider, at least one of the other panel members must be independent of the fostering service provider.

Regulation 25.—(1) The **functions of the fostering panel** in respect of cases referred to it by the fostering service provider are

- (a) to consider each application for approval and to recommend whether or not a person is **suitable** to be a foster parent,
- (b) where it recommends approval of an application, to recommend any **terms on which the approval** is to be given,
- (c) to recommend whether or not a person **remains suitable** to be a foster parent, and whether or not the **terms of their approval (if any) remain appropriate**—

Regulation 25.—(1) continued

- (i) on the first review carried out in accordance with regulation 28(2), and
- (ii) on the occasion of any other review, if requested to do so by the fostering service
- provider in accordance with regulation 28(5), and
- (d) to consider any case referred to it under regulation 27(9) or 28(10).

Panel Process (Operation Strategy)?

Quiz (Exercise 2)

The decision about whether to approve someone as a foster carer must be made within two weeks of the panel meeting? True/False (Why?)

Individuals involved in **assessing** the suitability of persons to be foster carers do not have to be qualified social workers? True/False (Why?)

A decision to change a foster carer's terms of approval can be implemented immediately by the fostering service? True/False (Why?)

(Workbook page 2-3)

Quiz (Exercise 2) continued

4. What does an Agency Decision maker do?
5. What has the Hofstetter v LB Barnet and IRM [2009] EWCA 328 (Admin) got to do with the role of the agency decision maker?
6. What is it when an agency decision maker makes a qualifying determination in contrast to a decision?

(Workbook page 2-3)

Quiz (Exercise 2) continued

7. Is the foster carer review complete when the review meeting is held, or when the ADM makes the decision?
8. When must a foster carer review be presented to panel?
9. Is it possible to change terms of approval without holding a foster carer review?

(Workbook page 2-3)

NMS and panel minutes

- 14.7) The panel chair ensures written minutes of panel meetings are accurate and clearly cover the key issues and views expressed by panel members and record the reasons for its recommendation.
- 14.9) The fostering service provider's decision-maker makes a considered decision that takes account of all the information available to them, including the recommendation of the fostering panel and, where applicable, the independent review panel, **within seven working days of receipt of the recommendation and final set of panel minutes**.

PANEL POWER RELATIONSHIPS

- Involve valuing the contributions of both children/ex children in care, foster carers-users and other professionals.
- Within teams, as within families, relationships vary and experiences can be mixed. Team relationships can involve **destructive** levels of understanding. McNeely (1994) found that, for nurses, communication with colleagues, doctors and departments was a major source of stress.

STATUS/POWER-COLLEGIAL ISSUES

Anderson et al (1995) reported that nurses were **dissatisfied** with their **status** and the **power** differentials built into their relationships with doctors; these acted as a **barrier** to **collegial relationships.**

EQUALITY AND INCLUSION ISSUES

- The imbalance of power between, say, purchasers and providers, social workers and domiciliary care workers, doctors and nurses, (supervising social worker and foster carer?), centres on images of race, gender and class between the individuals involved, all create unbalanced contributions, especially where these images and perceptions are internalized

S. Braye and M. Preston-Shoot, Keys to collaboration: 145, in Davis et al, Open University press.

SOME KEY MESSAGES FROM THE CORAMBAAF FOSTERING CHAIRS FORUM 24.03.15

1. A fostering review should always take place when the agency agrees a change to a foster carer change of approval
2. Fostering panels ensure an extra level of scrutiny
3. Foster carers should receive a list and all appropriate materials on such list of items being presented to fostering panels
4. Applicants and existing foster carers can decline offers to attend fostering panels

What research reveals

- It is some time since the Association of directors of Social Services (1997), when discussing the foster carer market found that ‘only 16% of foster carers reported they always attend training although 50% said they had access to training.

Child Abuse in foster care

- The single lesson learned is that child abuse takes place in foster homes, and this knowledge should affect the manner of selection, the speed of placement, and the social work contact in placement. (DOH, 1991, p97)

Utting report 1997, p 182

- Investigations into allegations of abuse in foster carer or residential settings differ significantly from investigations into allegations against parents or others in the child's home. Social workers find themselves examining the actions of people regarded as co-workers or professional colleagues.

Deaths and serious case reviews in foster homes

- Serious abuse on foster carer is rare,
- However, some inquiry reports and serious case reviews verify the fact that sometimes things do go seriously wrong in foster care, Brown (2011, 17)

The State of the Nation's Foster Care 2016 (Fostering Network)

- **49%** of foster carers did not have an agreed training plan
- **32%** of foster cares felt that children's social workers do not treat them as equals
- **31%** of foster carers reported that they were rarely or never given all information about a fostered child prior to placement
- **46%** of foster carers said their fostered children were not likely to receive information about independent visitors
- **61%** of foster carers who had experienced a placement ending said **it had not been preceded by a review**

Key Messages: Don’t become Complacent

- Key statistics (**Fostering in England, 2015-16 Ofsted)**
- During 2015-16, there were 2,450 allegations made against foster carers. Just under two thirds of these (63% or 1,550) were made by fostered children.
- Although the total number of allegations increased by 1% (from 2,420 to 2,450) from 2014-15, these came from a smaller number of children: the number from children decreased by 5% (from 1,640 to 1,550).

Fostering in England, 2015-16 Ofsted (2)

- Allegations against IFA foster carers were more likely to come from fostered children (75%) than in LAs, where the gap between allegations by fostered children (56%) and other sources (44%) was much smaller.
- Over half of all allegations were related to physical abuse, with allegations of sexual abuse being least common, much the same as in 2014-15.

Fostering in England, 2015-16 Ofsted (3)

- Continued monitoring was also more common for LAs (23% of allegations), than for IFAs (15%).
- As well as allegations against LA foster carers being more likely to result in continued monitoring, they also took longer to conduct the investigations.
- Just under 50% of all LA investigations took less than 21 working days (47%) compared to over 50% of those conducted by IFAs (59%). (Chart 17, overleaf)

Inquiry reports related to child deaths in general

Reder and Duncan, 2004, p96

- The consistency between the findings is striking, with particular clusters around: deficiencies in the assessment process problems with **inter-professional communication**; inadequate **resources**; and **poor skills acquisition or application**

Shirley Woodcock

- Shirley's death was recorded on 4 April 1982
- Shirley was age 3 years and 3 months and her sibling (brother) was age 4, when they were placed with foster carers on 10 December 1981
- Both children had considerable complex emotional needs that the serious review report summed up by stating – were more than their foster mother could handle

Shirley Woodcock report findings (1)

- Social workers visits to the family were not recorded

Shirley Woodcock report findings (2)

- Conflicting assessments between the fostering team and the LAC team, the former thinking the Shirley and her brother should be moved from the placement whilst the fostering team thinking was that a further move would be too disruptive for the siblings.

Shirley Woodcock report findings (3)

- The foster mother described Shirley as being a “faddy eater” whereas the same child had recently been described as having a good appetite

Shirley Woodcock report findings (4)

- Marks and scratches were noticed on Shirley's neck by a fostering officer on 28 January 1982 on a home visit and at the time Shirley was wetting herself, soiling and had sleep problems
- On 16 March 1982 a child minder visitor noticed a row of bruises around Shirley's neck which the foster carer explained as being self –inflicted
- A health visitor who saw Shirley on 19 March 1982 noted that there were problems in placement and around this time Shirley's nursery also reported bruising

Shirley Woodcock report findings (5)

- Shirley was admitted to hospital on 4 April 1982 with a head injury and fifty bruises on her body.
- Her brother, when examined, also had extensive bruising.
- Shirley was placed with the foster carer for just over four months and not seen by a social worker for a two-month period during this time.

Hammersmith and Fulham, 1984, p37

- At the point of approval, new foster parents are untried and untested. Thereafter, it must never be taken for granted that simply because they are approved as parents, they will always be able to cope.

Wakefield Inquiry (2007)

Examined the circumstances surrounding two male foster carers', IW and CF, sexual abuse of foster children in care

- They were approved by Wakefield Council in July 2003 as short term foster carers but were given prison sentences in June 2006 for the sexual abuse of four boys

Wakefield inquiry

- The foster carers fostered eighteen children during their relatively short fostering career.

- The carers were inexperienced foster carers who had many children with complex needs placed with them as a result of Wakefield council's shortage of foster carers, from July 2003 to January 2005 these newly approved carers looked after 18 different children each with substantial complex needs.

Parrott et al, 2007, p164

- The social workers may have experienced anxieties on their part about being seen as prejudiced against gay people.
- **The fear of being discriminatory led them to fail to discriminate between the appropriate and the abusive**.

Laird, 2010, pp 195-196), Practical Social Work Law, Analysing court cases and inquiries)

- **Many of the children placed with the foster carers had previously been sexually abused and exhibited sexualised and challenging behaviour.**
- **ANY ONE OF THESE CHILDREN WOULD HAVE PRESENTED CONSIDERABLE CHALLENGES IN TERMS OF THEIR CARE, EVEN FOR THE MOST EXPERIENCED FOSTER CARERS.**

Parrott et al, 2007, p88

- Like the Gloucestershire report regarding Mrs Spy [Gloucestershire Safeguarding Board, 2008], the Wakefield inquiry recorded the power of CF and IW to manipulate the system that was there to supervise, monitor and support. Related to a particular incident and their supervising social worker's failure to challenge the foster carers.

Parrott et al, 2007, p88, Independent inquiry Report into the circumstances of Child Sexual Abuse by two foster carers in Wakefield

Related to the SSW failure to challenge the foster carers, the report noted:

- This significant breach of their boundaries as foster carer was not addressed and challenged, once again signalling to CF and IW that they could be successful in bullying and manipulating the system to get what they wanted.

Parrott et al, 2007, p88, Independent inquiry Report int0 the circumstances of Child Sexual Abuse by two foster carers in Wakefield

- The Commission for Social Care Inspection noted that Wakefield Council's annual reviews had not always been undertaken on time.
- The foster carers had not written their annual report feedback report and the SSW had written it for them.

Wakefield enquiry

- In relation to the foster carers first review – it was late, had no comments from Looked After Children, had not been signed by the SSW's manager before being sent to the reviewing officer; the reviewing officer took two weeks before submitting his report to the fostering team
- **Despite the concerns** highlighted in the first review report by the LAC SW, birth parents letter of complaint about the foster carers **the review recommended the continued approval of CF and IW as foster carers**

Wakefield inquiry

- There is no evidence that IRO challenged or queried the statements or lack of key information in the report.
- **Recommendation 27 argues that foster carers' first reviews after their approval should be conducted earlier than the statutory minimum of a year.**

Hackney Serious Case Review (2014)

- Between 1999 and 2008, five girls of primary school age, who were all in the care of Hackney Council, were sexually abused in the foster home.
- This came to light in late 2012 after one of the victims made allegations to the police.
- In 2013, the male foster carer was convicted of more than twenty sexual offences against five looked after children which include rape, sexual assaults and acts of indecency.

Hackney Serious Case Review (2014)

- He was also convicted of offences against another child who lived in the local community and admitted sexual offences committed against an unidentified young person, committed some thirty years previously.
- A second male member of the foster family was also convicted of sexual offences against one looked after child.

Hackney Serious Case Review (2014)

- Two family members stated that the female foster carer knew that children were at risk of sexual abuse. She is now known to have been involved in sexual activity (not involving children) with other adults which took place in the family home.
- While not in itself illegal, had it been discovered this activity would have led to her deregistration as a foster carer. Both foster carers therefore had a strong motivation to keep what was happening in the household secret.

Hackney Serious Case Review (2014)

- Doubts about the carers' **motivation for fostering identified at the fostering panel** were not kept under review because initial placements with the carers were seen as being successful. There illustrates the risk (still potentially present in any fostering service) that individual workers and the service as a whole may develop an uncritical pride in and loyalty to 'their' foster carer. Services may be unwilling to challenge or criticise carers because they work with some extremely difficult young people and are a valued resource.

Hackney Serious Case Review (2014)

- Between 1999 and 2008 the male foster carer largely kept in the background as far as professionals were concerned. In contrast, the female foster carer was assertive and combative towards professionals. She used a number of approaches to undermine the credibility of the workers who raised concerns about the standards of care provided to the foster children. This included repeatedly criticising the competence and reliability of social workers in front of the children and making complaints.

Hackney Serious Case Review (2014)

- Hackney CSC fostering service and the **Fostering Panel**, should ensure that all assessments of foster carers are thorough, robust and appropriately challenging with information being sought from a wide range of sources whilst placing limited reliance on DBS checks. The desired outcome is that there is a high level of assurance on judgements about the ability of prospective carers to provide safe care.

Croydon Serious Case Review

- The length of time Claire was the subject of a Child Protection Plan was unacceptable: the impact of early trauma on children has been well researched and the effects of this trauma are likely to remain with Claire throughout adulthood. A much earlier decision should have been taken to remove Claire from this household.

Croydon Serious Case Review (2)

- Had there been adequate consideration of Claire's future, it would have been clear that Claire's paternal grandmother was willing to provide care, but this was never explored.

Croydon Serious Case Review (3)

- **Assessment and approval of Mr and Mrs George as foster carers, 14th February 2012:** The assessment of Mr and Mrs George was completed using a standard Form F assessment tool. The tool is in widespread use across the country and the format ensures all required fostering competencies are covered.

Croydon Serious Case Review (4)

- Although the assessing social worker was new to the role, all obligatory areas were covered within the assessment and a great deal of information was provided to evidence the competencies.
- However, the form did not promote sufficient critical appraisal of the information gathered, and as a result there was an absence of analysis.

Croydon Serious Case Review (5)

- The assessing social worker was employed on an independent sessional basis by the local authority; it is not unusual for fostering assessments to be completed by independently employed sessional workers. However, this meant that the social worker did not have accesses to routine management guidance or supervision.

Croydon Serious Case Review (6)

- Before the assessment went to panel, the assessment was seen by a manager. **This manager did not identify the absence of analysis as, in line with expected standards**, the focus of quality assurance was not on the quality of analysis but on whether the required competencies had been properly covered.

Croydon Serious Case Review (7)

- Within the Form F **information was presented that required further exploration**, scrutiny and analysis by the various managers and panel members responsible for quality assuring such assessments.
- Had this happened questions would have been raised about the truthfulness of the couple, their emotional stability and their resulting suitability to foster.

Croydon Serious Case Review (8)

- The social worker and the supervising social worker worked in different teams; they had different roles and responsibilities; were managed by different line managers; and **used different data recording systems**.
- **Close working relationships between these social workers was therefore difficult to achieve** and, whilst there were no structural barriers to achieving a close working relationship, the structures in place did not sufficiently facilitate this relationship.

Croydon Serious Case Review (9)

- **Renewal of Mr and Mrs George's approval as foster carers, 19th March to 14th May 2013:** The approval of Mr and Mrs George as foster carers was the subject of a routine annual review on the 19th March 2013.

Croydon Serious Case Review (10)

- During this review, panel members were rightly concerned about the suitability of Mr and Mrs George as foster carers. Concerns were focussed, not on the role of Mr George, who it was argued had a strong commitment to caring for Claire in the long term, but on concerns about the emotional health of Mrs George, her ambivalence towards Claire, and towards her fostering role.

Croydon Serious Case Review (11)

- **Information provided to the panel by the fostering team on these issues was inadequate**, and as a result panel members had differing views:
- **Four** panel members recommended the decision should be deferred until more information was made available,
- **Three panel members recommended the carers should be de-registered** and
- **Two** recommended the carers should not be re-approved.
- **The panel chair** made the decision to defer concluding the matter until more information was available.

Croydon Serious Case Review (12)

- At the next panel meeting on 14th May 2012, Mr and Mrs George attended. A revised report was provided by the fostering team and Mr and Mrs George answered questions put by the panel. The panel were told that Mr and Mrs George were now both fully committed to Claire, and to their fostering role.

Croydon Serious Case Review (13)

- Information provided by the fostering team in support of the recommendation for continued approval included confirmation that Mr George was now playing an active role in caring for Claire.

Croydon Serious Case Review (14)

- Additional information was provided that Mrs George was taking medication for panic attacks and was on the waiting list for counselling, and as a result her emotional health had improved. On this basis of this new information, the panel recommended continued approval.

Croydon Serious Case Review (15)

- **The information provided to the panel stated not only that Mr George was actively caring for Claire, but that he was often alone in her company.** Despite the existing agreement that Mr George should not be alone with Claire, **this was not questioned by the supervising social worker, or by the manager who signed off the report, or by the Panel or later by the Agency Decision Maker.**

Croydon Serious Case Review (16)

- The lack of sufficient scrutiny of the information provided to support the continued approval of Mr and Mrs George by managers and panel members meant that decision about the suitability of Mr and Mrs George was highly questionable. The issues raised previously, in relation to the poorly developed quality assurance mechanisms in place when deciding foster carer suitability.

Croydon Serious Case Review (17)

- *The vast majority of children entering foster care are provided with safe family placements, but in approximately 450–550 cases, children across the UK do experience harm each year from those responsible for their care.*
- *This is likely to underestimate the true extent of the problem as well over half of unsubstantiated allegations could not be proven one way or the other.*

Page 2

Issues for the Board and Individual Agencies (Croydon SCR)

Fostering Panel

1. What are the obstacles to achieving scrutiny and challenge of foster care assessments?
2. *Is the Fostering Panel made up of the necessary expertise to allow informed analysis of the information provided?*
3. How do panel members gain specialist advice when needed?
4. *What is the role of the Panel Advisor and how are any potential conflicts of interest understood and managed?*

Issues for the Board and Individual Agencies (Croydon SCR) (2)

5. *That quality assurance mechanisms are in place to review and evaluate the work of the Panel? How is performance measured?*
6. *How is the Independent Chair supported in raising and resolving any concerns in relation to the work of the panel?*
7. *Fostering Panel learning and development plan to reflect the learning from this finding and issues to be taken forward.*

Quality assurance

- The role of assessing social workers is to ensure that Agency policy and procedures are followed and they meet targets agreed in supervision. Social workers are expected to challenge, in writing, any quality assurance matters raised by the panel and the decision maker, which the worker is not in agreement with.

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Content Specification – (from MIND MAP)

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KNOWLEDGE	SKILL	ATTITUDE
1. Definitions of What makes a serious case reviews 2. Key fostering service Practice Involved in safeguarding children 3. Law 4 Signs + Indicators 5. Key working together – Lessons From inquiries	1. Communicating with Children 2, Using Procedures 3. Applying the Law 4. Acting upon Indicators 5. Working with the Safeguarding Children Network	1. Attitudes to working as part of the fostering team 2. Attitude relating to Gender, Disability, Ethnicity, Sexuality 3. Knowing the overall aims of the Agency and acting on your responsibilities within this role