Kingston & Richmond
Safeguarding Children Partnership

Child Safeguarding Practice Review
YPW
Summary of Learning

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1 PREFACE

This review concerns a young person (known in this report as YPW) who was abused in foster care. YPW has been involved through the review process and was asked if they would like to contribute a forward to the report. The following has been written by YPW and is a message to all professionals about the importance of understanding what functional illness is and how to respond. For YPW this is one of the most important lessons from this review and it is important that everyone has this in mind as they read through the report.

Information from YPW about functional illness so agencies can understand and support children going through explained or unexplained functional illness/ condition.

The symptoms of functional illnesses/ conditions for some can be short lived but for others it can go on for months or years and can be very disabling. Functional Neurological Disorders (FND'S) is the name given for symptoms in the body which seem to be caused by problems in the nervous system, but they are not caused by a physical neurological disease or disorder.

Some health professionals like to call these disorders "medically unexplained", "psychosomatic" (in the head but not factitious) or "somatic symptoms". I prefer and like to use the word "functional" as it means that the body or a certain part of the body is not functioning as it should.

Two main types of functional illnesses/conditions/symptoms:

1. Sensory symptoms:
Our brains are constantly bombarded by sensory information from millions of sense organs all over the body, including the skin, joints, muscles, internal organs, and other senses such as sights, sounds, smells and tastes. Most of this information is unimportant, and the brain very effectively filters it out so we are usually unaware of it. People can experience either "negative" symptoms (loss of sensation, vision loss, for example in ophthalmology one third of patients presenting get diagnosed with explained or unexplained sight loss) or "positive symptoms" (extra sensations, such as pins and needles or pain, or both). Symptoms can come on quite suddenly.

2. Concentration, Memory and fatigue:
When someone is struggling to concentrate, they are not able to filter out unimportant sensory information to focus on what is important. This can lead to feeling fatigued or exhausted which can be a common symptom and varies day to day.

Learning points:
Most children who end up in the care system have traumatic experiences or are going through trauma which can be a cause of functional illnesses/conditions. It is important that children who are diagnosed with a functional illness (i.e., those who have gone through neurology and are still being diagnosed with unexplained functional illness) receive psychological help to understand symptoms and possible causes. Social services should make sure these are

followed through and have an understanding of the diagnosis and should explore whether these could be as a result of current environmental factors.

2 INTRODUCTION

2.1 In July 2022, a young person in the care of the local authority (known in this report as YPW) told their social worker via text one Friday evening that they wished to speak with them at school. They did not want to speak in the foster home because if the foster carer knew they had asked to speak they would not be safe. This foster home was in a neighbouring Borough. YPW also spoke to staff at school on Monday morning detailing emotional abuse, neglect and physical abuse within the foster home and was moved to an alternative placement the same day.

2.2 Whilst living with the carers YPW had developed a functional illness which they recovered from shortly after the move to alternative foster carers.

2.3 After YPW had disclosed abuse within the foster home, strategy discussions took place. These did not result in formal police investigations, and the concerns regarding the behaviour of the foster carers were then managed via the local authority designated officer (LADO) and a standards of care investigation. During this process the other young people within the home were also moved to alternative provision. In January 2023, the standards of care investigation found that YPW's allegations about the foster carers were substantiated, and the author of the investigation report noted that had the foster carers not already resigned they would have been deregistered. The LADO requested that the local authority made a referral to the Disclosure and Barring Service (DBS). The reason for the delay is discussed later within this report.

2.4 In October 2022, Kingston & Richmond Safeguarding Children Partnership had received a serious incident referral in respect of YPW by the Designated Nurse for Children Looked After Children. This referral set out a series of concerns which indicated the potential for learning. These concerns included YPW not accessing child in care health assessments and not being taken to medical appointments, as well as recovering from functional illness after leaving the foster home.

2.5 As required with the statutory guidance[1] Kingston & Richmond Safeguarding Children Partnership carried out a rapid review of all known information, and a decision was made in December 2022 to commence a local child safeguarding practice review (LCSPR). The National Child Safeguarding Review Panel was notified of this decision and agreed that a local review was appropriate.

3 REVIEW PROCESS

[1] Working Together to Safeguard Children 2018 (this has been updated in 2023)

3.1 Please note that children's services in Kingston and Richmond is delivered by a social enterprise company, Achieving for Children (referred to as AfC throughout this review). AfC have provided all statutory children's services in LB Richmond since 2014.

3.2 The lead reviewer for the LCSPR was commissioned in February 2023 and a review panel appointed. The first panel meeting took place at the end of March 2023, prior to which chronologies had been received from the agencies known to have had contact with YPW.

3.3 The review panel agreed the key lines of enquiry for the review. These were:

1. What was the lived experience of YPW and other children and young people in the placement?
2. What do we know about the history of the foster carers, including the quality of assessments when they applied to be foster carers?
3. How effective was the process for the supervision of foster carers and how can the system take a whole family approach which evaluates stressors within the foster carers family alongside any signs from children in the placement which may indicate concerns?
4. What assumptions might be made about foster carers capacity to provide safe care and what are the barriers to recognising and challenging safeguarding concerns?
5. How effective is the health system at triangulating information across providers?
6. How well do current processes (i.e. the decliner pathway) support the escalation of concerns when a child in care is not accessing the full range of health services that they need?
7. Is there sufficient understanding and appropriate training for health agencies in meeting the health needs of children in care. e.g. Level 3: All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a looked after child/young person or care leaver?
8. In a permanent placement how can a balance be achieved between delegating appropriate authority to the foster carer whilst ensuring that the local authority fulfils their role as corporate parent and the child's voice is heard?
9. How can the safeguarding partnership be assured that there is an appropriate level of independence within standards of practice investigations in foster care and that the implications for all adults and children associated with the household are fully explored?
10. How far did the Covid pandemic impact on capacity to challenge the foster carers and provide opportunities to understand what life was like for children and young people living in the household?

3.4 It was agreed that the approach to this review should be to work alongside YPW and (taking account of their wellbeing) include them as far a possible throughout the process. Contacts with YPW were agreed through their social worker and/or therapist and current foster carer. Two initial meetings took place in May and June 2023, and these were invaluable to helping the panel to understand the issues that were most important to YPW. These issues centred around:

- Lack of trust in social workers as a result of removal from their birth mother and placement with the carers who abused YPW. YPW told the review that *they took me away from the person I loved the most and after I was taken away I had people that I did not know, know everything about me.* People who YPW trusted at the time they were removed included staff in the primary school, but YPW understands that the carers pushed for them to move to a school nearer to the foster home.
- Foster carers exploiting YPWs naivety by controlling behaviours including keeping YPW away from reviews and encouraging suspicion about medical assessments.
- YPW's belief that AfC staff were friends with foster carers and remain so to this day. This impacts on YPW's belief that this review can be successful in exploring what should have been done differently to identify the abuse and keep them safe.
- Emotional harm within the foster home including being treated differently to other young people in the home and being told when upset to *move on* and being accused of *going mad like your mother.*
- Neglect which included being sent to live with and care for the foster parent's mother (who had been diagnosed with dementia) during the covid lockdown, having to share her bed and not always having enough food.
- Physical harm from the foster carers' own child which included YPW being tied up with and held under water.

3.5 At this stage of the review YPW was still fearful about the reactions of others to her disclosures and:
- felt strongly that they did not want the foster carers to be involved in the review process,
- did not want the other young people in foster care to be directly spoken to
- did not want a senior manager from AfC involved in the review panel as they had significant contact with YPW over several years and YPW did not feel they could be totally professional.

3.6 The panel wished to respect YPW's requests and agreed to exclude the foster carers from the review and not to contact the other young people but to keep this under review and discuss further with YPW as the review progressed. The review was able to achieve an understanding of what happened in the foster home from the perspective of all the young people involved through the very detailed accounts that the young people had given to the standards of care investigation and discussions with their social workers. This informed the analysis in this draft of the report.

3.7 YPW was shown a copy of the final draft report to check that this accurately reflected their experiences and to consider whether they would like to add comments at the front of the report. YPW suggested various amendments which have been incorporated into this final version. These included an additional recommendation. YPW also felt strongly that professionals should read the report with an understanding of their experience of functional illness and they prepared a page for professionals which has been included at the start of this report.

3.8 The expectation of the National Safeguarding Review Panel (in statutory guidance) is that learning in the form of a review report should be shared via the local partnership's website.

YPW was consulted about the level of detail that is shared publicly and has agreed the final report for publication.

The limitations of this review

3.9 The absence of foster carer input into the review is a limitation. There is a significant gap in our understanding as to why the foster carers behaved in the way they did. We have respected YPWs wishes not to involve them in the review, and alternative means by which their motivations could be understood have not been possible as there have been no police enquiries and the foster carers did not engage with the standards of care investigation.

3.10 The review also struggled to put together a full and accurate timeline of events to inform the analysis – both in relation to YPW and the other young people in placement. The chronology from AfC did not include all relevant details and gaps only became clear as the review progressed. The neighbouring Borough had not been involved at the rapid review stage and it gradually became apparent that there was significant information both from YPW's secondary school and the SEND service that needed to be gathered and incorporated into the review. The need for comprehensive information gathering at an early stage in future reviews has been addressed by the partnership in discussion with relevant agency colleagues.

4 SUMMARY OF LEARNING

4.1 This review was commissioned because a young person (YPW) disclosed emotional, physical abuse and neglect by their foster carers. YPW lived in the home for several years after being removed from their birth family under a care order. Whilst living in the foster home YPW had was diagnosed with a functional illness but recovered when moved to a different placement. A standards of care investigation found that the allegations made by YPW against the carers were substantiated and the carers would have been removed from the foster care register, if they had not already resigned.

4.2 YPW is understandably angry that those agencies with a responsibility for keeping children in care safe, failed to recognise, investigate and act on the abuse they were experiencing in the foster home. One major lesson from listening to YPW is the overwhelming fear associated with speaking out and the importance of receiving a clear message that they have been heard, and actions have been taken to hold the foster carers to account.

4.3 The review has considered a number of interacting factors in order to try and understand why the abuse was not recognised. The findings and recommendations reflect the issues which seem to have affected the ability of individuals and agencies to recognise what was happening. However, these findings should not detract from an acknowledgement of the harm that has been done to a young person who depended upon statutory agencies to provide protection and repair after removal from their birth family.

4.4 The circumstances explored during this review partly took place within the Covid-19 pandemic which increased the potential for the carers to keep professionals at a distance.

Finding One

Young people in care may find it hard to trust professionals who have been involved in their removal from their birth family. In this case the foster carers assumed too much power, resulting in a failure of the system to hear the voice of the child.

4.5 YPW had been removed from their birth family and was told at the time that they were lucky to be placed with the Borough's best carers. For a child who could not understand why they had been separated from their mother, it is perhaps not surprising that in these circumstances they trusted the foster carers rather than the local authority; a dynamic that YPW has recognised and spoken about after leaving the foster home. In addition, the foundation was laid for a belief that the carers were all powerful, untouchable and friends of social workers. YPW had four different social workers during their time with the carers, meaning that there was insufficient time to build up the trust that was needed to talk openly about their experiences.

4.6 There was an overreliance on the carers to be the voice of the child and the power of the foster carers was located in the perception that they were a strong advocate for children in their care. Consequently, when they told social workers that YPW did not wish to attend reviews or medical assessments this was understood as conveying YPW's wishes and feelings advocating on their behalf. We now know from the young people involved that they were persuaded by their carer that they should not attend.

4.7 YPW's feeling of powerlessness was reinforced by the reluctance of social workers to fully explore concerns about the foster carers, raised by other professionals in the system. The use of the complaints system by the foster carers was not recognised by others as a means of control and deflection away from their own behaviour.

4.8 YPW's symptoms of functional illness (which were very real) can now be understood as most likely linked to experiences within the foster home and was a communicating anxiety and distress; but once again YPW's voice became lost. This is explored further in Finding Three.

Finding Two

There was an overreliance on experienced foster carers as a safe pair of hands and insufficient analysis of the impact of changing family dynamics on their capacity to foster. Concerns about foster carer behaviours were not adequately addressed and shared with other professionals working with children placed in the family.

4.9 The foster carers were highly regarded within the Borough and social workers felt positive about the care they offered over several years. However, it is now clear that there were a number of stresses within the family and some issues were actively kept from the local authority. Annual reviews of the carers did not fully explore wider family dynamics and how these might be impacting on young people in their care. They tended to gather information electronically rather than giving professionals space to reflect on their perceptions of the foster carers work.

4.10 There were some accumulating concerns about the carers which resulted in four complaints as well as direct contact by a senior health professional to AfC. A fact-finding report made some recommendations for improvement but practitioners who had responsibility for children in the home including social workers and independent reviewing officers were not

aware that this action had been taken. There was therefore a lost opportunity to recognise patterns of behaviour that could be a cause of concern.

4.11 Communication between AfC children's social workers and supervising social workers for the carers was not well established and this combined with limitations in the annual review process meant that the totality of accumulating concerns was not understood.

Finding Three

Functional illness was not recognised and responded to within the child care system as a response to anxiety or trauma, and communication across education, health and social care (in respect of YPW as a young person in care) did not allow a full picture to be developed of the best way to manage the condition and meet YPW's needs.

4.12 YPW was diagnosed with unexplained sight loss which was understood by specialist ophthalmologists as a functional illness and was treated as such. Relevant diagnostic tests were carried out to exclude an organic cause, followed by referral to psychological therapy, and reassurance given to YPW and the foster carer that (although YPWs symptoms were real), YPW should not be treated as blind and, given time, sight would come back.

4.13 However, whilst functional illness is not uncommon in ophthalmology, it is not part of the day-to-day experience of children's social workers. The implications of functional illness and the best way to respond were not well understood and consequently there was a focus on managing YPW's symptoms rather than exploring the root cause, including the possibility of a link with current anxiety or trauma.

4.14 This lack of understanding was exacerbated by communication being direct from hospital consultants to the GP and foster carers rather than including social workers. This communication pathway also excluded the health team for children looked after which is a significant gap as they could have provided a link between specialist health settings and social workers. The importance of the referral to psychological therapy via the ophthalmologist and the significance of the failure of the foster carer to take YPW to the appointment became lost. In contrast the carer had been diligent in attending other medical appointments and pushing for a variety of diagnostic tests, thus giving the impression once again that she was a strong advocate for YPW.

4.15 The lack of understanding of the implications of functional illness extended to plans for YPWs education provision. Coordinated planning was also hindered by YPW residing in a neighbouring Borough with the Education Health and Care Planning being managed outside Richmond. The approach to the Education Health and Care Plan (EHCP) did not take account of the importance of understanding the nature of YPWs functional illness and access to right psychological therapy.

Finding Four

The specific dynamics of the relationship between the foster carers and AfC contributed to a situation where health and mental health provision for YPW lacked coordination and failed to recognise the part that the foster carer played in this fragmented approach to health care.

4.16 Given the complexity of YPW's functional illness it would have been very important for there to be a robust coordinated approach across health and social care. This was, in part, prevented by the foster carer controlling which medical appointments YPW attended. As a result, YPW did not attend medical assessments for children in care for several years. The foster carers report that YPW did not wish to attend was taken at face value by practitioners in AfC, based on a perception that the carer had YPWs best interest at heart.

4.17 Multi agency oversight of YPWs health needs did not work well and was negatively impacted by staff shortages in the health children in care team during covid and delays in sending the required paperwork from the social work team to health. This combined with the lack of communication from hospitals to social workers contributed to a lack of a coordinated multi agency response across AfC and health to properly explore what lack of medical assessments alongside functional illness meant for YPW and next steps.

4.18 Multi agency oversight of YPW's access to mental health services also did not work well. Richmond child in care health services were unaware of the ophthalmologist's referral for psychological therapy and there was no follow up when YPW was not taken to the appointment.

4.19 Within Kingston and Richmond, Tier 2 (early help) child mental health services are delivered via a small team within AfC rather than via health services. This team were not aware of YPW's full medical history and there seems to have been no joined up approach that pulled together all the strands relating to attempts to provide the appropriate psychological/therapeutic provision for YPW.

Finding Five

When allegations were made about the foster carers swift action was taken to remove YPW. However, the way other expected systems and processes were used resulted in a delay in protecting other children in the placement and a lost opportunity to ensure that YPWs voice was heard. In addition, the local authority where the foster carers lived was not informed or involved in strategy discussions.

4.20 It took a great deal of courage for YPW to tell their social worker that they were frightened living in the foster home and then talk in detail to staff at their school. The local authority did respond swiftly by removing YPW from the home on the same day as the disclosures, but from that point expected procedures were not used to hear YPW's account and protect other young people in the placement. This resulted in YPW feeling that they had not been believed.

4.21 The local authority designated officer (LADO) was not informed immediately the allegations had been made and a strategy meeting took place eight days after YPW disclosed abuse. The local LADO was not invited nor was the LADO from the neighbouring local authority. This was a significant gap as there was no discussion of possible risks to other children who had contact with the family.

4.22 YPW had made it clear that they wanted to speak with the police and show them something on their mobile phone, and the advice from the police that there needed to be more clarification of information before an Achieving Best Evidence (ABE) interview was arranged was inappropriate. The lack of police interview following a request from the young person

was interpreted by YPW that they were not really believed. No police attended a second strategy discussion, and it was not until some weeks after the allegation that YPW was visited by two uniformed officers who seem to be unaware of YPWs original wish to share mobile phone evidence and did not raise this when they met. The only outcome from this meeting was a crime of common assault (due to the male foster carer throwing a remote control at YPW) being noted but it was also noted that the statutory time limits on prosecution had run out as the assault was three years ago.

4.23 Once the LADO had been informed, a standards of care investigation did commence but again there was no liaison with the local authority in which foster carers lived. The standards of care investigation had found allegations against the foster carers to be substantiated. No immediate referral was made to the Disclosure and Barring Service (as would be expected practice) as there was some confusion as to whose responsibility this was. It was later clarified that this was the responsibility of fostering service, and a referral was made.

4.24 It is important to reflect on how the failure to follow expected procedures left YPW viewing the events in the immediate aftermath of the disclosure with some suspicion and did not feel believed.

4.25 Having read the whole review YPW commented that there is a need to improve information sharing (including during the LCSPR) and that partnership working must be actively encouraged between police, health, AfC and the Safeguarding Partnership. This forms the basis for recommendation thirteen.

5 SUMMARY OF RECOMMENDATIONS

Recommendation One

AfC should use this case to develop guidance and training for social workers, supervising social workers and independent reviewing officers on:

- best practice in hearing the voice of the child and promoting the use of advocacy for the child in foster care especially in established long term placements.
- developing the skills and confidence to act authoritatively and challenge carers if the child is not being heard.

Recommendation Two

Kingston and Richmond Safeguarding Children Partnership should examine any barriers preventing the escalation of concerns from any agency where a professional believes that foster carers behaviours are not being appropriately challenged and addressed.

Recommendation Three

AfC should consider developing guidance regarding work mobile phone communication which includes:

- ensuring that children and families are aware of the limitations of this form of communication outside working hours
- the potential for mobile phones to be checked and monitored as a form of coercive control.

Recommendation Four

Routine communication pathways should be established between supervising social workers and the social workers for all children placed with a foster carer. These pathways should ensure that:

- The annual review is used as a dynamic process that moves beyond a paper-based exercise and includes a fresh pair of eyes overseeing the annual view on at least a three yearly basis.
- Where there has been a formal investigation into foster carers the original concerns and outcome of the investigation is always be shared with independent reviewing officers and the social workers for all children in the placement.

Recommendation Five

Kingston and Richmond Safeguarding Children Partnership should work with the Metropolitan Police to:

- ensure that officers attending domestic abuse incidents take a proactive approach to establishing the occupation of people in the home including always enquiring about who lives in the household,
- explore whether an alert can be added to police records where the adults are registered foster carers

Kingston and Richmond Safeguarding Children Partnership should work with the Metropolitan Police to:

- ensure that officers attending domestic abuse incidents work in line with expected procedures and take a proactive approach to establishing the occupation of people in the home including always enquiring about who lives in the household,
- explore whether an alert can be added to police records where the adults are registered foster carers.

Recommendation Six

AfC and health professionals for children in care should review the use of the delegated authority document in order to ensure that it is a live working document that informs day to day practice and is regularly reviewed.

Recommendation Seven

AfC should ensure that where a child or young person in care is diagnosed with a functional illness, this triggers a professionals meeting in order that the child’s care plan can be reviewed. The meeting should include practitioners with a specialist understanding of possible underlying causes and effective treatments.

Recommendation Eight

Where a young person in care has been referred for an Education Health and Care Plan (EHCP) AfC should ensure that:

- If they reside outside the Borough and planning for education is delegated to the authority where they live, all meetings include the AfC social worker and virtual school as the local authority holding parental responsibility.

- There is always relevant health expertise present to inform decisions.

Any barriers to implementing this recommendation should be identified and brought to the attention of the relevant national body by Kingston and Richmond Safeguarding Children Partnership

Recommendation Nine

Kingston and Richmond Safeguarding Children Partnership in collaboration with Designated professionals should establish and implement a communication pathway between health organisations for children in the care of the local authority. This should include reinforcement of the KRSCP Was Not Brought Policy and to always include the local authority as corporate parent in all communications if a child is not taken for medical appointments.

Recommendation Ten

Safeguarding training for all professionals should be revised to include content on best practice in safeguarding of children in care.

Recommendation Eleven

Kingston and Richmond Safeguarding Children Partnership should work with AfC and the Metropolitan Police to ensure that all practitioners know how to respond to allegations against a person of trust and that this knowledge is embedded in practice.

Recommendation Twelve

AfC should consider how to assure children who have made allegations that they have been heard whilst being mindful of legal duties to maintaining confidentiality in respect of the carers.

Recommendation Thirteen -YPW's recommendation

AfC should improve record keeping and data sharing with reviews and all agencies involved in safeguarding children should work together with the Safeguarding Partnership to encourage collaborative working.