**DORSET SAFEGUARDING CHILDREN BOARD**
**SYNOPSIS OF LEARNING FROM SERIOUS CASE REVIEWS**
**February 2017**

# Serious Case Review Family S23

## INTRODUCTION AND BACKGROUND TO THE CASE

The DSCB completed a Serious Case Review in 2016 in relation to the potential serious harm of two Children placed in Foster Care within Dorset. This synopsis of learning has been formulated to reflect the challenges facing those working with Children in Care who present with a Learning Disability or make allegations against their carers.

The children, having been known to Children's Services since their birth were placed with a fostering couple and remained in that placement until the death of the carer in 2015. It is understood these children have a learning delay and have challenging communication and behaviour.

Following the death of the main carer, the children were placed elsewhere. At that point, one child then disclosed sexual abuse in relation to the male carer, had an ABE interview. Based on this interview, the child was deemed credible and worthy of investigation. However this investigation was unable to corroborate the disclosure of sexual abuse.

## LEARNING

### Safeguarding Disabled Children

- It was clear that children within the 'Looked After' system are often no longer perceived to be at risk against a backdrop of those children who are deemed to require robust monitoring and are subject to Child Protection procedures. The children's voices had been lost and despite considerable input from the multi-agency network, continued to be at risk, Child A having been identified specifically as having suffered significant harm. Disabled children and young people should be seen as children first. Having a disability should not and must not mask or deter an appropriate enquiry where there are concerns.
- Agencies need to recognise that more often than not Schools have access to, and understanding of children in their care far more than other agencies or even carers. This should be supported by arranging meetings at schools or around school timetables where possible.
- S23 identified that practitioners can use euphemistic language which, although understood in context can be misinterpreted. An example is use of the words 'Complex needs' which must be expanded during recording so all practitioners have an unequivocal understanding of what these needs are.

## Voice of the Child

- Practitioners must see children alone and must hear their voices. This case identified little evidence of children being seen and understood away from carers. This meant an over reliance on foster carers to interpret the child's needs.
- It was evident from the S23 that the children may have been attempting to disclose or raised concerns as to their care throughout the time they were placed with their carers. The SCR comments that disclosure may have been an on-going process where practitioners may have felt the children were voicing concerns but had not reached the threshold for allegation or recognition of disclosure. In the NSPCC report No One Noticed No One Heard it was recognised that many incidents of child sexual abuse go unreported, and delayed disclosure is common. Children may disclose sexual abuse by directly telling someone about it. They may also disclose less directly, sometimes unintentionally, over a period of time, through a variety of behaviours and actions, including discussions and indirect non-verbal cues. In this respect, disclosure should be seen as a process that occurs over time
- Where there are concerns voiced by children, these concerns should be shared in a multi-agency forum where the risk is shared and appropriate decisions can be made.
- The Voice of children must also be recorded; this is not only the words but also behaviours which may offer evidence of concern or of good practice. These should then be shared as appropriate in any multi-agency forum.

## Lack of Professional Curiosity and Relevance of Management Oversight

- There is a need to foster professional challenge and oversight, so promoting best practice. Supervisors must challenge, and offer space to reflect on cases where there is conflict and professional difference. Practitioners must be able to voice concerns about the practice of others.
- Managers must be accountable for their supervision and decision making. This should be recorded appropriately on case files and individual's supervision records. Managers and practitioners are responsible for ensuring these decisions are recorded appropriately.
- Concerns about foster carers must be dealt with appropriately and the LADO should be involved in ensuring best practice in this area of work. Should it be seen as necessary, Foster carers should be referred back to the fostering Panel in a timely fashion and any investigations in to allegations should be undertaken independent of the Fostering teams. This is underpinned by: 'Procedures for Investigating Allegations against all Carers', approved under 'Fostering Services National Minimum Standards, Fostering Services Regulations, (2011).
- Fostering Panel reviews and appropriate timescales must be adhered to in order that we meet 'Fostering Services National Minimum Standards, Fostering Services Regulations, (2011).

### Use of The Escalation Policy

- Referral information across agencies should include historic information where appropriate. Individual concerns seem to get minimised. Professionals should expect and receive feedback on referrals, duty is not discharged until appropriate feedback is received.
- Practitioners should know the escalation policy and be assertive in any escalation. It is clear practitioners felt disempowered by the robust challenge of the foster carer and a lack of knowledge of appropriate avenues to challenge strengthened that position.
- Agencies must be able to evidence their practitioner's ability to challenge and escalate appropriately.
- It was highlighted that practitioners were not aware of how much information they could share so were reticent to share. If there is multi-agency engagement, all practitioners should be able to share with consent of the family unless to engage the family would increase the risk to the child.

## ENSURE THIS REPORT MAKES A DIFFERENCE

There are lessons to be learned for anyone who reads this. Please ensure you are listening to children in care. Find ways to understand what they are saying and believe them.

Please complete some feedback in respect of this learning by answering the survey below.

## PLEASE GIVE US YOUR FEEDBACK

Think about the learning points in the Synopsis of Learning you have just read and send us your thoughts via the following survey:

***https://www.surveymonkey.co.uk/r/SB6FYZ6***

The comments you provide will be consolidated with those made by others and presented to the DSCB in order for them to work to ensure that Serious Case Reviews make a difference to children's lives.

**Please complete your survey by 31 March 2017**

Thank you