Gloucestershire Safeguarding Children Partnership

Local Child Safeguarding Practice Review (LCSPR)

THE LIVED EXPERIENCE OF A CHILD IN OUR CARE

2023

"A child's voice, however honest and true, is meaningless to those who've forgotten how to listen."

JK Rowling

Voice of the Child:

Children need to be more clearly heard in decisions about their future. ... Although they are often at the centre of proceedings, the views of children and how they feel are often not heard, with other people making vital decisions for them. This not only refers to what children say directly, but to many other aspects of their presentation. It means seeing their experiences from their point of view.

This LCSPR was undertaken and written via a multi-Agency working group set up under the governance of the GSCP Quality and Improvement in Practice Subgroup of the Gloucestershire Safeguarding Children Partnership.

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1. THE LIVED EXPERIENCE OF A CHILD IN OUR CARE

1.1 The Voice of Child C

Child C has given the GSCP permission to use this statement as part of this review. Please take time to read and digest what Child C has to say before continuing with the rest of the report.

I am a victim of child sexual abuse and rape. I am still discovering all the ways that this abuse has affected me, hurt me, destroyed my childhood, teenage years that every person deserves.

My foster father started abusing me when I was 16 years old. He used what I now know are common ways in which abusers get their victims ready for abuse and keep them silent: he told me that I was special, different, that he loved me and that we had our own "special connection".

Since he was a trusted person that I had lived with from a young age, my mother, father, and family didn't suspect anything whilst I was in his care. At first, he would send me messages saying he was going to come into my bedroom at night and say goodnight to me and then things started from there. I remember he tried to give me oral sex at first and that was very confusing.

I remember when he tried to have sex with me for the first time and that hurt even more and was terrifying knowing his wife and my social worker were just downstairs. I remember telling him it hurt. I remember many times that he would take me to the shops to buy underwear to wear for him or he would buy it for me and lay it out under my pillow so I could feel it as I got into bed so I could be ready for him that night or the next morning.

After the abuse he would comfort me and tell me how much he loved me and how he was so in love with me. Even now when I may get into a relationship and hear the words of comfort and love it gives me strong feelings of panic, guilt, and humiliation. It's like I can never get away from what happened to me.

At the time I was confused and knew it was wrong and that it didn't feel comfortable but at the same time it also felt wrong telling someone about my foster father who lived in the same house as me who was telling me he loved me and that I was in a relationship with him. He told me we had to take what was going on "to the grave" and that if I ever repeated anything to my friends or family it would be my fault and his relationship with his family and relatives would fail because of me.

There is a lot which is hard to remember but I still can't forget the feeling of what he did to me as it was at such an early stage of my life. For a long time, I tried to take the terrible memories out of my mind. Thinking about it now is still really painful.

Sometimes I am doing everyday things such as watching tv or am in a shop but small things such as smells, and tastes will cause me to be reminded and taken back to that time in my life.

When I first spoke up about the abuse and what my foster father was doing, I went to therapy and thought I was getting over it. I was very wrong. My full understanding of what has happened to me has only gotten clearer as I have grown older. My life and feelings are worse now and it hurts knowing my innocence as a child and young person and how it was taken away from me by someone who was in a position of trust and power.

1.2 Introduction

In October 2020, a young person shared with their friend about being abused by their foster parent. As the young person was still living in the foster household, along with other young people it is essential to emphasise the courage demonstrated by this young person in disclosing the abuse.

Although it is incredibly difficult to comprehend that any Child in Care placement would provide a venue to perpetrate further abuse of children and young people, sadly we know that this can and did happen even within the expected systems of monitoring, oversight and management of both foster carers and children living in Care Placements. We need to understand more about how agencies advocate for children and young people so that their voice is heard, and opportunities to openly share their experiences are placed uppermost in all professionals' practice.

In undertaking a Rapid Review of learning, Gloucestershire Safeguarding Children Partnership seeks to understand what happened and what needs to change. This LCSPR looks to specifically understand and learn from the lived experience of Children in Care in Gloucestershire using the following key questions:

- Are we ready to see beyond formal or perfunctory processes so that we listen and hear their voice and see their true experiences?
- How are we responding to concerns whilst being entirely child focussed – listening to them and not placing judgements on the veracity of allegations.
- Are we consistently believing children and enabling early disclosure of concerns by them?
- At the start of any foster placement, how do we explain to the child what is appropriate treatment in the foster placement and how they raise any concerns they have confidentiality? This is particularly important for children from a background of interfamilial sexual abuse.
- Do we consider foster carers as safeguarding professionals, parents, trusted adult? And how does that impact on our ability to respond appropriately when situations such as these occur?
- As professionals working with Children in Care in Gloucestershire, do we acknowledge and consider that 'terrible things can happen' to Children in Care?
- How are we ensuring that we provide a consistent trusted professional, aside from those who have caring responsibilities?

The Child Safeguarding Practice Review Panel, National Annual Report 2020 (DfE), highlights key practice areas. Theme 1: 'Understanding what the child's daily life is like' that resonates here and has directed the partnership to consider how we could have listened more. What could professional have done better to improve the child's lived experience and have their voice heard?

1.2 What Happened to Child C?

Child C experienced early trauma and harm through Neglect, Physical, Emotional and Sexual abuse by their birth family. Following the conclusion of care proceedings, whereby a full Care Order was granted, Child C was placed with carers whom they had spent some respite time with previously. Gloucestershire Fostering Panel considered and approved this as a long-term match, and this was confirmed as the plan at a Child in Care (CIC) review in October 2016, Child C was 13 years at this time and had lived with the foster family since August 2016.

At age 14 years, Child C was accessing social media material. There were some professional concerns about online grooming, but also what was described at the time as a relationship between Child C and an older child of the foster family; Child C had disclosed information but then retracted it.

At aged 16 years Child C then made a call to the Emergency Duty Team talking about being 'emotionally manipulated' by the female foster carer and stating that the allegation made previously aged 14 had been true. One year later Child C called ChildLine asking about the legal age of consent, telling them they were in a sexual relationship with their male foster carer; Child C went on to deny this call was made.

Within a few months of Child C's call to ChildLine, further separate allegations were raised by two different young people about two different members of the foster family; one was of alleged sexual assault, and another was about use of physical force

Child C's storyline was drawn together and explored thoroughly within the Rapid Review. This LCSPR has sought to build on what was known and as such has evidenced how Child C's story presented differently to different people and professionals. Child C's behaviour and what they said varied, meaning that no one professional or agency had the full picture of the child's daily life and how things were for them, as a child living in Care, coming from a background of harm and neglect, and continuing to endure abuse.

This report can say that disconnection in communication meant interdisciplinary and multi-agency discussions did not join up effectively if at all around Child C.

1.3 Publication Note:

The GSCP accept that this LCSPR is being published outside of the six-month timeframe set out in the Working Together 2018 Guidance. The partnership considered that a sensitive and balanced approach was needed and to capture learning from the two parallel processes underway. It was considered by the working group to be vital to ensure that a full picture of what happened to this child could be understood to identify the learning from all the circumstances surrounding the child. In addition, the desire to engage with and involve the child required the partnership to fully understand and mitigate against any potential conflicts with the child's testimony within the current and ongoing criminal proceedings and most importantly to capture the child's voice without re-traumatising them.

2. LCSPR Report and Recommendations

It is pertinent to remind readers that the review is in place to determine what the multi-agency partnership and hence individual agencies could have done better to understand the lived experience of a child in the county. This review is focused on what we can learn and how we work to change practice.

2.1 Providing a Consistent Trusted Adult

The report 'Your Life Beyond Care,' which captures the views of care leavers in Gloucestershire on their well-being & what makes life good (June 2020) sets out the voice of the child in care and leaving care and clearly communicates those children in Gloucestershire value consistent and trusted workers "as a very important quality in relationships…."

Baker, 2017 "…care leavers were clear about the qualities they valued in workers such as, someone who was responsive, consistent, and reliable…"

As set out in the 'Child Safeguarding Practice Review Panel, National Annual Report 2020; "It is important for practitioners to build a trusting and respectful relationship with the child". For Children in Care, the foundation and framework for a trusted support network must surely begin with those social care professionals surrounding them.

The day-to-day care and permanence plan for a Child in Care is overseen by the locality children's social care team (including the permanence teams), the fostering team, the participation team, and Independent Reviewing Officers (IRO). Additionally, other principal agencies and professionals involved in providing care were Primary Care, the Child in Care Nursing Team, Child Adolescent Mental Health Services (CAMHS) and the School Nurse service. Also, two Secondary schools and engagement with the Virtual School provided education services.

From entering Local Authority Care Child C experienced changes of social worker which included 10 to 16 different professionals who were a mix of permanent and agency staff. Child C had several professionals working around them and an Independent Reviewing Officer was allocated from October 2016 to August 2019. This would suggest constancy of a professional; however, the records indicate the involvement of several other Independent Reviewing Officers during this time, making it hard to be confident that there was consistency in the oversight and monitoring of Child C's care planning.

At no point was Child C expressing that there was anyone in their view as an identified and trusted individual.

Throughout 2016 to 2020, a period indicated by Child C as the time in which the abuse was occurring, the frequent turnover of professionals from within the partnership meant building a trusting relationship would have been difficult for any child. The system assumed that the trusted professional was the Foster Care family, a family who latterly were under some scrutiny for a range of issues relating to their suitability to care for children to an acceptable standard.

It is positive that the allocated social worker at the point of disclosure had been in place since 1st February 2019, but this worker has since moved on. Following the disclosure and as part of this review the social worker met with the child and asked for their view on why they felt unable to disclose sooner, this is what the child relayed. (Names have been changed for confidentiality).

"Child C said they felt there were times they wanted to talk to me (social worker) and call me, even though they had my number but was worried that the (carer) would hear the conversation.
Child C said they were not ready to tell people what was happening sooner, they said they wanted to get evidence and was worried they would not be believed. ….and said they were so worried that the (carer) would find things on their (Child C's) phone and delete them so there would be no evidence."

"Child C said they didn't feel ready to tell people before they did. Child C said they wanted to tell me (Social worker) before I left and me telling her I was leaving the service triggered her to wanting to tell people sooner as she wanted to tell someone she had known for a long time rather than someone new"

Child C would have been aware that they would shortly get another worker but was still not confident or trusting enough to tell the social worker because from their own experience they did not feel they would be believed.

The service had a long-standing relationship with Child C's foster carers. These foster carers were considered by the service as 'good carers' and labelled as designated 'champions' for other foster carers. Historically their standing and reputation within the service and community of carers quite likely led a potential for 'absolute unquestioning trust,' discounting and misinterpreting Child C's actions and behaviours.

Prior to the final disclosure from Child C, in July 2020 concerns had been raised by another child in the care of the foster carer's which led to the agency questioning one of the carers' standards of care and suitability as a foster carer. However, these concerns were in their infancy and not related to the sexual abuse allegation by Child C. The service response to these concerns will have contributed to Child C having less confidence to share the abuse they were experiencing, feeling they may not be listened to and in the absence of a single trusted professional Child C was on their own.

In this case Child C's abuser was seen by professionals as part of the team around the child. However, Child C has stated that they did not have a trusted professional to turn to that would believe them. This leads us to ask how the Partnership can be assured that a child is able to identify and build a trusting relationship with a professional. In many cases children may not wish to challenge who others feel that trusted person is thought to be, and whether they really feel they have a professional who is focused on them. This indicates a need for clearer guidance and understanding of professional roles and accountabilities linked to how being a 'trusted professional' is articulated and developed in line with the findings of GCC's Fostering Service Review.

It would appear the expectation is that Children in Care are required to repeatedly renew and develop trusting and respectful relationships with different professionals, not just with Social Care. Other agencies were involved to review, support and advise on the child's physical, developmental and mental health needs. Child C was talking about their relationships, feelings, and sexual activity but in diverse ways and to different degrees within these contacts.

The reality of life for Child C and other Children in Care is challenging and potentially exhausting, with no one external professional who will attune to their needs, to hear and see beyond the surface presentation. In addition, the situation for Child C shows the lack of a collaborative or shared approach to sharing information despite the Child in Care plan and review system. Parts of Child C's story known to health were missing in the bigger picture. The partnership must also consider how professionals include foster carers as part of the team around the child, whilst ensuring they remain entirely cognisant of the possibility for abuse and neglect perpetrated within families and foster placements. There must be assurance that every child has a key professional who is truly their advocate.

2.1.1 Activity

The Gloucestershire Childrens' Social Care Improvement Board is overseeing and monitoring activity and approaches to improve worker stability and the role of the trusted professional. Representation

from Gloucestershire's Ambassadors will include the voice of young people and a commitment to improve has been pledged.

Completing Life Story work will inform assessment, analysis, and planning with children, thus directly informing risk assessment and better supporting the needs of each child. GCC Children Social Care (CSC) has employed a Life story coordinator to further develop and ensure consistency in relation to life story work for all Children in Care. A pilot project was undertaken with a cross section of children within children's teams focusing on embedding life story practice. This is in the form of a guide and toolkit now available for all social workers, meaning they can undertake Life Story work with children. This supports close collaboration and dialogue between practitioners, teams, carers, and families to encourage awareness and understanding of key aspects of each child's life and their experiences, promoting identity, promoting their self-esteem and stronger relationships into adulthood.

This Review understands that Life Story work has now been rolled out across all localities, with an expectation that all social workers will have the skills and knowledge to undertake life story work with all Children in Care. Also, Participation Champions in all teams meet regularly with the Principal Social Worker and Gloucestershire's Ambassadors to update on the progress of life story and direct work and to share examples of effective practice for wider development in teams.

GCC Childrens' Social Care should share their completed report on Life Story work formally with the partnership, with their commitment to report on its impact and outcomes for Children in Care. This is further linked to additional relational practice focused activity, social graces training and emphasis on 'language that cares' that continue to be highlighted across the service.

2.1.2 Recommendation/s:

Recommendation One: Whilst the identification and reporting of abuse of any kind should not be left to children to undertake there must be confidence that our Children in Care have a voice and are empowered to use it. **At the appropriate time the Local Authority must lead on talking to children about healthy relationships, conversations that are age and developmental stage appropriate to support Children in Care to understand appropriate treatment and behaviours in their foster placement.**

Recommendation Two: Where there is little or no evidence that a child feels they have a trusted professional all efforts to understand and improve that situation must be considered and acted on. **Therefore, professionals should ensure that the role of the trusted professional or adult is explicit within the Children in Care planning process and should never be seen as being undertaken solely by a Foster Carer.**

Recommendation Three: To avoid duplication with activity already being undertaken and reported on: **Activity within the Gloucestershire Children Social Care Improvement Board should be shared with the GSCP with regards to improving worker stability and the role of the trusted professional /adult**

Recommendation Four: To reinforce the importance of the voice of the child the Partnership should consider working with young people and Gloucestershire's Ambassadors to: **Create a short film for professionals about continuity of engagement, the importance of listening to the child's voice and**

enabling the child and professionals to develop trusted relationships. This to be cascaded across the partnership.

2.2 Adult Focus

Child C lived in the care of foster carers known by professionals to be trusted and experienced, working with the authority over many years and revered as supportive 'champions' for other foster carers. Up to the final disclosure the trusted status and circumstances of the foster carers surrounding Child C remained unchallenged; and yet throughout this time the child was being abused in their care.

At so many points the professional focus was demonstrably on the views of adults, not listening to the child's voice or understanding their help seeking behaviour. Any attempts for Child C to express themselves and reach out for help were either disbelieved, dismissed, not followed up or involved the carers, causing the child to retract statements and say they had lied.

Decisions for the foster carer themselves to discuss concerns with Child C following indications of online grooming and suspected sexual contact with the foster carers eldest child in 2017 was flawed and lacked professional curiosity. Likewise, there was a lack of response in June 2019 when Child C, in a call to the Emergency Duty Team, stated they wanted to move placement and that their allegations previously made in 2017 about the foster carers child's behaviours towards them, were true and that the female carer "*emotionally manipulated them*". There was no consideration of a conflict of interest or inappropriateness in them self-investigating the situation with Child C. This was symptomatic of the adult focused approach undertaken throughout.

A further allegation from another child outside of the care of the foster carers in June 2020 against the (same) child of the foster carers was reviewed through an Allegations Management Meeting (AMM) process, given as they at that time were a young person employed to give their views on issues and themes affecting young people in this county. This allegation did not consider the previous concerns raised by Child C regarding the foster carer's child in 2017, as information regards the Strategy Discussion that took place at that time, was not shared and the LADO was unaware of this information.

The ongoing determination by professionals that both the concern in 2017 and the allegation (by a second child) in June 2020 were consensual relationships did not display the appropriate level of professional curiosity or rigor. Further, following the information from Child C's call to ChildLine, Child C should not have been considered as a consensual relationship with the foster carer. This activity would be considered an abuse of trust; the foster carer would be behaving in a way that had harmed a child leading professional to question their suitability to work with children, regardless of the child's later withdrawal of that allegation.

The decision that threshold was not met in February 2020 from the ChildLine disclosure, regardless of Child C's decision to deny this call, was incorrect. The child's mobile number could be verified against that call, leading the review panel to conclude that the context and understanding of Child C's withdrawal of the allegation was not explored. On the balance of probability, the option for a Strategy Discussion and an Allegations Management Process was missed. At the very least a Strategy Discussion should have been instigated to consider all possibilities. Instead, the view was taken that "we do not have enough evidence for a strategy discussion at this time" which was also the position taken with regards to an AMM.

All professionals working with children, young people and their families and carers must be alert to the possibility of child abuse being perpetrated by any adult. We must question how we are responding to concerns whilst being entirely child focussed, and not placing judgements on the veracity of allegations or concerns, or a child's decision to withdraw or deny making allegations. Are we consistently hearing the voice of children, sustaining paramountcy for the needs of children, listening to children, believing what they say in their language and in the way they are behaving and presenting to us? All professionals must be attuned to the child's voice and experience in this way to enable early exposure of risk to harm faced by children.

2.2.1 Activity

The GSCP Quality and Improvement in Practice Subgroup have oversight of all Multi Agency training via its Quality Assurance group. All Multi agency training has been reviewed regarding the inclusion of the Voice of the Child and the Childs Lived Experience. This work will be cascaded through to all Single Agency training as delivered by the partners and within Education Whole School Training.

The GSCP Standard four as set out in the Section 11 audit assesses agencies arrangement with regards to the Voice of the Child which is reported on by the Independent Scrutineer from 2020 and on an annual basis. A copy of this report will be shared with the I.S. for consideration in 2021 S11 audit panel day.

As a result of this review and report the partnership is reviewing their approach and expectations of strategy discussions. This work has been underpinned with a revised protocol for Strategy Discussions with follow-on activity and monitoring through the GSCP Quality and Improvement in Practice Subgroup

Scrutiny of the GCC Allegations management process with regards to the Voice of the Child and Lived Experience of the Child is being considered within recommendation 7.

2.2.2 Recommendation/s

Recommendation Five: To reinforce the importance of the voice of the child: **Agencies should review all Single Agency Training to provide assurance to the GSCP that the voice of the child is present and for them to provide evidence of impact on practice.**

2.3 Adherence to Statutory Process

Abuse by carers is not unthinkable, as evidence locally and nationally shows. Compliance with statutory duty alone does not keep children safe from harm. At no point in this child's daily life did any professional question whether multiple disclosures, retractions, and incident reports, across different systems and processes consider Child C was making cries for help. What must that have felt like for the child?

The serious allegation made in June by a second child against the foster carer's child was managed through the Allegations Management process; a process designed to focus on "adults in a position of trust." While there was a Strategy Discussion, there remains little evidence of a proactive or robust safeguarding response. What response there was merely stated there was a lack of evidence to instigate criminal proceedings or even HR Disciplinary Proceedings. The Fact that processes sought

and followed advice that was focused on Employment Law threshold again demonstrates a focus on the rights of the adult and not the welfare of the child.

Although there is information to show in Child C's situation that process was inconsistently followed, there remains a pervasive attitude that compliance with process is a barometer for successfully meeting Children's needs. That compliance saw a child being coerced and sexually abused whilst partners were being compliant with duty. We must surely turn this around to promote professional curiosity and a true understanding of the lived experience of the child.

Processes to manage allegations against professionals require careful thinking and aligning with safeguarding practice. The partnership must place the needs of the child as paramount, whilst fully utilising statutory processes to manage criminal and professional allegations appropriately.

Strategy Discussions should have taken place in 2019 and 2020. This information sharing opportunity with the key professionals supporting Child C would have focussed on the child's perspective, bringing greater analysis and challenge to their circumstances regarding understanding and managing risk and thus afford Child C greater protection. The decision to not undertake Strategy Discussion's has been seen in Gloucestershire from other Rapid Reviews. Under a backdrop of an existing high rate of strategy discussions in Gloucestershire there clearly remains confusion over the remit and threshold of combined or dual processes even where information is available.

The evidence in this case and other SCR's, LCSPR's and Rapid Reviews suggests that where criminal threshold is not met there is a propensity for partners to consider safeguarding threshold to be dispensed. More worrying, the default position seems to be where criminal threshold is not met or where a decision on criminal threshold is "no further action." Disclosures, allegations, and other clear messages from children are neither believed nor acted upon under safeguarding duties. This is concerning as the ability to hear the child's voice and understand the lived experience of children is the first casualty.

Gloucestershire Safeguarding Children Partnership must fully understand local decision making when there are concerns about Child Sexual Abuse (CSA). In this case CSA was not ever considered until the video footage was disclosed by the child. Why is that? The review feels that the absolute and unwavering trust in the carers blinded all professional curiosity and the complete deafness to the voice of the child.

2.3.1 Recommendation/s

Recommendation Six: SCR's and Rapid Reviews undertaken in Gloucestershire identifying the need for practitioners to be confident and competent in being always alert to the potential for, identifying and responding to signs and symptoms of Child Sexual Abuse: **The QiiP should revisit the findings of safeguarding reviews to seek assurances from partners about actions to address them.**

Recommendation Seven: Concerns relating to an adult focus within statutory functions needs to be explored and addressed: **The Local Authority should undertake a review of its Allegations Management Processes and report back to the GSCP on its findings and actions to improve identified areas for improvement.**

3. Update on Parallel Processes

- An immediate joint Complex Abuse Investigation was undertaken, within GSCP policies and procedures. During that investigation agencies came together and worked quickly with all the children, including Child C, so that their needs were at the centre of the decision making. This LCSPR has been informed of the findings of the Complex Abuse Investigation, indicating there were no other criminal prosecutions to be undertaken. The findings have been shared with GCC's relevant service.
- The local authority undertook an independent review of their Fostering Service. The report was made available to the GSCP and this LCSPR.
- Criminal proceedings have concluded.
- Now criminal proceedings into the Foster Carers have concluded, GCC Fostering Service will undertake their own investigation into their suitability under the Fostering Regulations 2011.

4. Summary

We must act robustly in response to indicators of abuse whether children are living with their families or in the care of the local authority and proactively seek to protect children, rather than waiting for abuse to occur and relying on children's disclosures to take protective action.

At the same time as instilling a culture where indicators of abuse are effectively understood and assessed, we must create the safe spaces in relationships with trusted professionals that provide the best conditions to support children feeling able to tell professionals if they are being abused or suffering harm.

Practitioners must be open to considering that abuse by professionals and trusted carers is possible and respond accordingly when indications of professional abuse become apparent; think the thinkable.

GSCP should not consider this to be an incident suffered by a Child in Care but should consider this to be an incident suffered by a child. As such, and as Corporate Parents, the support and response to these circumstances must be robustly challenged as they would be for any one of our own children, niece, nephew, or grandchildren.