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Impact and Evidence series

KEEPING CHILDREN SAFE: ALLEGATIONS CONCERNING THE ABUSE OR NEGLECT OF CHILDREN IN CARE

FINAL REPORT

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with Susan Clarke

June 2014

UNIVERSITY of York

Impact and Evidence series

This report is part of the NSPCC's Impact and Evidence series, which presents the findings of the Society's research into its services and interventions. Many of the reports are produced by the NSPCC's Evaluation department, but some are written by other organisations commissioned by the Society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.

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Acknowledgements

We would like to thank the NSPCC for sponsoring this study and, in particular, Tom Rahilly for his support and encouragement throughout. We would also like to thank Robert Tapsfield and Alison King of the Fostering Network, our partners in the research, for their helpful advice and assistance. Thanks are also due to Rebecca Thompson and Heather Milnes for their invaluable administrative support. Finally, we are very grateful to the LADOs (and other designated officers), fostering managers, fostering social workers, residential managers and heads of homes across the UK who found time to assist us with our surveys.

EXECUTIVE SUMMARY

For most looked after children and young people, foster and residential care provides a safe environment. This study has focused on the minority of children who do not always receive safe care and who, in some instances, experience abuse or neglect at the hands of those responsible for ensuring their wellbeing. Despite long-standing concerns about historic abuse in children's homes and about the implications of allegations for foster carers and their families, very little is known about the extent of these allegations. We know even less about the proportion of allegations that are substantiated, the nature of the abuse and neglect experienced by some children in care settings and the characteristics of the adults and children involved.

The aim of this study was to investigate these important questions. It provides new UK evidence on:

- the number of allegations against foster carers and residential social workers and the proportion of these that are substantiated
- the extent and nature of confirmed abuse and neglect in foster and residential care
- the characteristics of the children and adults concerned.

Study design

The study covered the period 2009–2012 and the design included:

- Phase 1: a survey of all 211 local authorities in the UK to map out the scale of substantiated and unsubstantiated allegations in foster and residential care over these three years. The response rate was high (at 74 per cent; 156 local authorities), but Northern Ireland was underrepresented in the survey;

- Phase 2: a follow-up survey of 111 substantiated cases of abuse or neglect (87 in foster care and 24 in residential care), concerning a total of 146 children. The purpose was to identify the nature of the abusive or neglectful behaviours in these confirmed cases, the characteristics of the adults and children involved and the consequences for all concerned.

It is important to bear in mind that the Phase 2 sample is quite small. In particular, the findings in this Phase in relation to residential care should be considered exploratory.

The study concerns allegations referred to senior managers responsible for investigating allegations against people working with children (LADOs in England or their equivalents in the other UK countries). Our focus was on allegations and confirmed abuse or neglect made against adult carers (or other adults linked to the placement) and to incidents that arose *within* placements. The study therefore largely excludes incidents that took place away from the placement, allegations concerning other children living in the placement and those that were not considered sufficiently serious to require formal investigation by LADOs (or their equivalents). An exploration of the views of the foster carers was also beyond the scope of this study.

The incidence of allegations and confirmed abuse or neglect in foster care

On average, local authorities reported 10–11 allegations per area in each year of the study, giving a UK estimate of approximately 2,000–2,500 allegations per year. This represents fewer than four allegations per 100 children in foster care across the UK each year (3.38–3.83 depending on the year). Between one-fifth and one-quarter of these allegations (22–23 per cent depending on year) were confirmed as abuse or neglect. The majority of allegations were therefore not substantiated.

Extrapolating from these figures, we estimate that there are likely to be 450–550 confirmed cases of abuse or neglect in foster care across the UK each year. This represents less than one substantiated allegation per 100 children in foster care across the UK each year (0.80–0.88 depending on the year). This suggests that, although many foster carers may be the subject of allegations, only a tiny proportion of them are involved in confirmed cases of abuse or neglect. Maltreatment in foster care nevertheless warrants serious attention, since no child should experience abuse or neglect in a foster placement and the consequences for children can be very damaging.

More detailed information was available from a sub-sample of 85 local authorities. In these authorities 26 per cent of all allegations were confirmed and 30 per cent were considered to be unfounded. However, 43 per cent of allegations were unsubstantiated due to a lack of evidence to either prove or disprove them.

Where clear evidence is lacking in this way, professionals are often presented with difficult dilemmas when deciding on an appropriate course of action. Children may be removed from placements quickly when circumstances do not justify it, causing unnecessary disruption in their lives. Alternatively, they may be left in situations where they are exposed to further harm. Equally, foster carers who have done

nothing wrong may see children removed and may remain under unwarranted suspicion.

Where allegations were substantiated, well over half of the children had been permanently removed from placements (56–63 per cent of cases, depending on the year). Where cases could not be substantiated, however, 13–16 per cent of the children were nonetheless removed.

Numbers of allegations and of confirmed cases of abuse or neglect varied between England, Scotland and Wales and, within England, between local authorities. These patterns did not appear to relate to differences in the size of the fostered population in different areas. Our data cannot tell us the extent to which these differences are real or the product of different policies, procedures and recording practices.

The vast majority of children entering foster care are provided with safe family placements, but a minority of children across the UK do experience harm each year from those responsible for their care.

Our findings are likely to underestimate the true extent of the problem, as over half of unsubstantiated allegations could not be proven one way or the other.

Allegations that are unsubstantiated due to a lack of evidence can pose serious dilemmas to practitioners trying to decide on a safe course of action for the child. It is important (whenever it is considered safe) that some time is taken (in conjunction with colleagues) to carefully weigh the evidence in individual cases in an effort to avoid precipitate action.

Further work is needed to understand the variation that was found between countries and local authorities in rates of abuse or neglect in foster care.

The nature of abuse and neglect in foster care

The study described the nature of confirmed abuse or neglect for 118 fostered children. All forms of maltreatment were evident, including physical abuse (in 37 per cent of cases), emotional abuse (30 per cent), sexual abuse (11 per cent) and neglect (17 per cent). In addition, 15 cases were reported to concern poor standards of care falling sort of actual abuse.

Many of the foster carers involved in substantiated cases (43 per cent) had been the subject of previous allegations. It is important that an accurate record of allegations is maintained so that future incidents can be placed in context and emerging patterns of behaviour detected.

Abuse or neglect may occur in all placement settings and at any point in the life of a placement. However, while this study provides evidence that abuse and neglect can occur in any kind of foster placement (whether with kin or with strangers), it cannot tell us how likely these are to occur in kinship placements relative to placements with non-relatives, nor in long-term versus short-term placements.

There was evidence, however, that warning signs were sometimes missed when children appeared to be settled in long-term placements. Some children, for example, only disclosed persistent sexual and/or emotional abuse after they had left the placement. It is essential that social workers see children alone on a regular basis and, while recognising that most foster carers provide good care, are alert to the possibility of abuse in foster placements. Risks of non-disclosure can be heightened when children lack opportunities to confide in social workers and the monitoring and review of placements, even apparently settled placements, are insufficient.

In a number of cases the foster carers concerned had been under stress (related to the numbers or mix of children in their care) or had experienced personal difficulties (related to family illness, marital breakdown and excessive alcohol use) that stretched their capacity to provide sufficiently good care or led to the abuse of children. However, in a small number of very serious cases involving the persistent neglect, emotional and/or sexual abuse of children, it was clear that the foster carers concerned should never have been recruited. High quality assessment, recruitment and review procedures are needed to prevent these individuals being able to harm children.

Communication and information sharing between agencies was not always sufficient. Concerns raised by schools, neighbours or other relatives had not always been acted upon. Visiting children, listening carefully to what they say and spending some time with them away from placements are of fundamental importance. However, social workers also need to be mindful of information passed to them by others and employ their own professional skills to assess the changing dynamics of placement relationships. Not all children will feel able to disclose the abuse they are suffering.

The vast majority of substantiated allegations led to further action against the foster carer(s) concerned. One in 10 received no further action, one-third were provided with further support and training and, in almost one-half of cases, it led to termination of their approval to foster. Small numbers were referred to the Independent Safeguarding

Authority (as it was then) or were subject to criminal prosecution. Where the outcome involved no further action or support/training it was considerably more likely that the child would remain in placement.

The findings emphasise the importance of continuous monitoring and review of foster placements by social workers. Maltreatment can occur in any kind of placement at any time, even where children have been settled for a long time.

Listening carefully to children, both inside and outside the placement, is essential. However, it is important to be mindful that some children may not feel able to disclose abuse until after they have left.

Good cooperation and communication between agencies and between local authorities (where children are placed out of area) is imperative for effective safeguarding practices. Without this, important signals of distress can be missed.

Past allegations and concerns about foster carers should be carefully recorded. Any new allegations that arise should be placed in historical context.

Like other people, some foster carers will experience periods of distress and personal difficulty in their lives. Although the vast majority will not go on to mistreat children in their care, these signs should not be ignored. The offer of support may help to preserve the quality of care provided.

Foster carers will also need access to good independent support and representation once an allegation is made.

Where a foster carer is removed because their actions or behaviour suggest they may pose a risk of harm to children, the Disclosure and Barring Service must be informed.

The incidence of allegations in residential care

Information on allegations in residential settings was sought for the same three-year period (2009–2012). The survey was concerned with allegations of abuse or neglect by residential staff. As such, it did not include abuse by resident peers, abuse experienced while away from the home, or by adults external to placements.

As we found in relation to foster care, most young people in residential care did not suffer abuse or neglect from those charged with caring from them. On average, local authorities reported five to seven allegations per area in each year, giving a UK estimate of approximately 1,100–2,500 allegations per year. This equates to between 10 and 12 allegations per 100 children living in residential care across the UK in each year of the survey (9.56–11.91 depending on year).

Like foster care, between one-fifth and one-quarter of these allegations were substantiated (21–23 per cent, depending on year). As with foster care, therefore, at least three-quarters of allegations were unsubstantiated.

Extrapolating from these figures, we estimate there are likely to be around 250–300 confirmed cases of abuse or neglect in residential care across the UK each year. This represents between two and three confirmed allegations per 100 children in residential care each year (2.15–2.59 depending on year).

Unlike foster care, however, allegations (confirmed or otherwise) were much less likely to lead to young people being removed from placement. Fewer than one in five substantiated allegations resulted in removal.

Residential staff teams do provide safe care to the vast majority of their young residents, although across the UK there are an estimated 250–300 confirmed cases of maltreatment in residential settings each year.

As with foster care, this is likely to underestimate the true extent of the problem and takes no account of abuse by peers or adults external to the placement.

Unlike foster care, confirmed abuse is much less likely to lead to young people being removed from residential placements.

The nature of abuse in residential care

The study reports on substantiated allegations that concerned 28 young people in residential care. Four allegations originated from a single secure unit that was subsequently closed down, and another three from a single residential education unit. These units appeared to be marked by cultures of physical coercion and compliance in which the physical abuse of children may have been systemic.

Over one-half of cases concerning residential staff were categorised as either physical abuse or use of excessive physical restraint. These cases were similar in nature, generally involving staff reacting inappropriately to episodes of challenging behaviour by young people.

While there was recognition of the intense pressure felt by residential workers when conflicts erupt in children's homes, respondents highlighted the need for staff to remain calm, maintain a sense of authority and to employ strategies that help to defuse tensions in high-pressure situations. Work undertaken with young people in calmer times on an appropriate range of anger management strategies may also help to reduce aggressive behaviour.

Very few young people were removed from placement, and looked after children reviews to assess care planning needs were rarely held. In most respects, therefore, life went on much as before. Outcomes for staff were much more variable: while some were subject to no further action, others had their employment terminated. The reasons for differing outcomes were hard to discern from the data available to us.

The ability to maintain calm under pressure is essential when managing conflict and may be helped by positive training, support and supervision. In these ways practitioners may develop a repertoire of de-escalating strategies to reduce the tensions inherent in high-conflict situations.

Where children's homes work well, they tend to feature strong leadership, a positive culture that staff and young people are able to buy into, and to promote close inclusive relationships between staff and young people. Helping young people to find ways to manage their anger can help to reduce combustion within the home.

The inspection regime must eliminate the small number of residential units that continue to maintain cultures of coercion and compliance, even where these are accommodating very challenging young people.

Where a member of staff (paid or voluntary) is removed because their actions or behaviour suggest they may pose a risk of harm to children, the Disclosure and Barring Service must be informed.

Local authority data management and communication

Although all English local authorities are required to report annually on allegations to Ofsted, these data do not currently provide evidence on the numbers of children involved or on the proportion of allegations that are substantiated. The study identified gaps in the information that is readily available to local authorities. In many areas, no or only partial information on allegations was recorded on the central database. Where it was recorded, it was not always held in a format that could be linked to information held on children and caregivers. Good data linkage is needed to support local strategic planning.

Problems were also identified in communication between local authorities where children were placed out of authority. The host authority assumed responsibility for investigating allegations, but the extent to which the placing authority was kept informed or records were maintained of the investigation varied considerably. In these scenarios, effective care planning for the child could suffer.

At local authority and national levels aggregated statistical data on allegations are needed that are child-centred and can provide an accurate picture of substantiated abuse and neglect in foster and residential care.

For children placed out of authority, clear communication strategies between local authorities are needed to ensure effective management of investigations and care planning for the children concerned.

Conclusion

The vast majority of children who enter the public care system in the UK are afforded protection and most receive good quality care. However, a significant minority experience further harm at the hands of their caregivers. Abuse and neglect arise in both residential and foster care. It may occur in any type of placement at any time. Turning one's gaze away from children apparently settled in long-term foster care is not acceptable.

The confirmed abuse and neglect reported in this study ranged from minor indiscretions or failures to follow due procedure to the prolonged sexual and emotional abuse of children. Clearly, the same response does not fit all cases. Precipitate action may not always be warranted – especially given that, once removed from placement, children only very rarely return. In relation to more minor indiscretions, therefore, seeking solutions through negotiation, training and review may prove to be the most helpful approach for all concerned.

Greater access to support, training and specialist therapeutic support may help residential staff and foster carers to better manage the disturbed and challenging behaviour of some children and, in so doing, may reduce the risk of burn-out and stress-related abuse. However, strong selection and assessment procedures are also needed to prevent individuals who may present serious harm to children becoming residential workers or foster carers.

There is no substitute for high quality supervision of frontline staff, for the effective monitoring and review of placements, and for good cooperation and communication between agencies involved in the lives of children. With regard to these, the coordinating functions of Local Safeguarding Children's Boards, of Independent Reviewing Officers, and of LADOs and their equivalents in other countries have a pivotal role in coordinating and monitoring services, ensuring the safety of children and undertaking investigations into allegations.

Inter-agency communication is particularly important when abuse or neglect is identified in out of authority (private or voluntary sector) placements, to ensure that all other agencies using these placements are informed of the results of any investigations into foster carers or children's homes.

Some children do make unfounded allegations. Their reasons for doing so are complex. A fair and proportionate approach should be taken when investigating allegations and the foster carers and residential care staff concerned should be provided with information and independent support while under investigation.

It is essential that both foster and residential care are underpinned by a child-centred, rights-based approach, which ensures that children and young people are listened to and appropriate action is taken if they experience poor quality care, abuse or neglect.

Chapter 1

The research and policy context

Concerns about abuse in foster and residential care have been expressed, intermittently, for over 70 years. In the early post-war years the homicide of a child by his foster carer and wider concerns about the care of children in residential institutions led to the setting up of official inquiries in England and Scotland (Curtis Committee, 1946, Clyde Committee, 1946, Sen et al., 2008). These in turn led to moves to improve the care of children in care including, notably, the passing of the Children Act 1948. Around 30 years later *Who Cares?* – a report by young people in children's homes in England and Wales – provided evidence that abusive care was nevertheless a continuing problem (Page and Clark, 1977). However, it was only when a series of scandals regarding abuse in residential care came to light in the 1980s that public and professional attention turned again to this issue. At this point, the focus was principally on residential care.

Revelations about abuse in residential institutions from the 1960s (and often earlier) to the mid-1990s prompted the government to commission a number of inquiries (Hughes, 1985, Levy and Kahan, 1991, Kirkwood, 1993, Department of Health, 1993) and reviews of residential child care (Utting, 1991, Skinner, 1992, Warner, 1992). These were followed by reviews of safeguards for children living away from home in Scotland, England and Wales (Utting, 1997, Kent, 1997). In response, the English government published a detailed set of recommendations and set up the three-year *Quality Protects* programme to radically overhaul services for children living away from home, especially those in public care (Department of Health, 1998a, Department of Health, 1998b). There has been no systematic investigation into whether or not abuse by caregivers continues to occur in children's homes since the development of policies to safeguard children in residential settings subsequent to the above inquiries and reviews (see below). In the absence of such an investigation, we cannot be sure that the changes introduced as a result of the inquiries into historic abuse have had the desired effect of safeguarding young people in residential care.

In contrast to the picture for residential care, much of the discussion about abuse in foster care in the UK has centred on the problem of unfounded allegations of abuse, but there is very little evidence available on the extent and nature of either allegations or confirmed abuse in foster care (Biehal and Parry, 2010, Biehal, 2014). Unsubstantiated allegations create immense stress for both children and carers, may cause placement disruption and may reduce the already

inadequate supply of foster carers. In cases where such allegations are substantiated the implications are even more serious.

The limited evidence available suggests that abuse or neglect can indeed occur in foster and residential care, but the extent and nature of any such abuse or neglect is unknown. This study represents the first systematic attempt to investigate these issues in the UK. In this chapter we set out the context for the study, briefly summarising the available evidence on abuse or neglect in residential and foster care.

1.1 Allegations of abuse or neglect

The investigations into historic abuse in residential institutions prompted some questioning of the safety of convictions of residential staff. Criticism of the 'trawling' methods used by police investigating historic abuse and a questioning of the motives of some adults making allegations about historic abuse have been accompanied by debates about whether or not these investigations constituted a 'witch-hunt' (Beckett, 2002, Smith, 2008, Corby, 2006, Webster, 2005). In England a Home Affairs Select Committee noted concerns about "the over-enthusiastic pursuit of these allegations," but the government refuted this claim, stating that that there had not been a large number of miscarriages of justice (Home Affairs Select Committee, 2002, House of Commons, 2003). Concerns about unfounded allegations against residential staff persist. In Scotland, a review of abuse in residential child care noted a lack of clear evidence regarding the number of false allegations, but residential staff nevertheless continue to be fearful about the risk of abuse allegations (Davidson, 2010, Sen et al., 2008).

There have been similar concerns in relation to foster care. Since the 1980s, the Fostering Network and its predecessor the National Foster Care Association (NFCA), have drawn attention to allegations of abuse against foster carers (The Fostering Network, 2006, The Fostering Network, 2004a, Nixon and Verity, 1996, Swain, 2006a, Hicks and Nixon, 1989). This concern is shared by the Department for Education in England, the Scottish Government and the Department for Children Schools and Families in Northern Ireland (Department for Children Schools and Families, 2009, Department for Education and Skills, 2006). Unfounded allegations are profoundly upsetting for foster carers, can lead to the removal of children from their care and may also result in some carers giving up fostering.

The UK evidence on allegations of abuse in care tends to be piecemeal. For example, a study of referrals to social services or the police focused solely on sexual abuse by adults working or volunteering with children in eight local authorities between1988 and 1992 discovered only 22 *referred* (not necessarily confirmed) cases

concerning foster carers and 14 concerning residential institutions over a four-year period (Gallagher, 2000).

Although there have been several UK studies of allegations of abuse in foster care since the 1980s, most have had non-representative samples of foster carers (Biehal and Parry, 2010). The most reliable UK evidence on allegations in foster care comes from a survey of 950 foster carers conducted in the mid-1990s, 16 per cent of whom reported that they had been the subject of allegations at some point in their fostering career. However, surveys of foster carers may be subject to sampling bias: on the one hand, foster carers who have experienced unfounded allegations may be more likely to respond than those who have not, while on the other hand foster carers whose abuse or neglect has been confirmed are unlikely to remain in the foster care system and so are not included in surveys of foster carers (Wilson et al., 2000). For these reasons, the current study collected information on the extent of allegations and confirmed abuse from agencies rather than foster carers. Also, the likelihood of ever experiencing an allegation naturally increases over time. It is therefore more useful to know how many foster carers experience an allegation in a specified period.

Surveys that collect data from fostering agencies rather than foster carers and measure the number of allegations in a defined period are therefore likely to provide a more accurate picture. Just two UK studies, both conducted some time ago, have surveyed social work or fostering agencies about allegations. In the mid-1990s the NFCA collected information on 7,619 foster homes from just under half of all English social services departments and found that 4 per cent of foster homes were investigated for allegations of abuse in the year of the survey (Nixon and Verity, 1996), while a survey of all social work departments in Scotland reported that 3.5 per cent of foster carers had experienced allegations in one year (Triseliotis et al., 2000). However, these surveys did not indicate how many children or incidents were involved in the allegations. More recently Ofsted found that up to 4.4 per cent of fostering households in England and up to 2.6 per cent of approved foster carers experienced allegations in a single year (Ofsted, 2012). Half of these allegations led to enquiries under Section 47 of the Children Act 1989 (which relates to a local authority's duty to investigate child protection concerns).

1.2 What is known about abuse or neglect in residential care?

The physical, sexual and emotional abuse that occurred in children's homes across the UK from the 1960s to the 1990s has been well-documented. In the early 1980s the Kincora Inquiry was set up following in revelations of sexual abuse at nine boys' homes and hostels in Northern Ireland (Hughes, 1985). This was followed

by a series of reports in England during the 1990s: the report on the Pindown regime in Staffordshire (Levy and Kahan, 1991), the Leicestershire Inquiry (Kirkwood, 1993) and the Aycliffe Investigation (Department of Health, 1993). The Edinburgh Inquiry in Scotland (Kent, 1997, Marshall et al., 1999) and the Waterhouse Report in Wales (Waterhouse, 2000) were followed, in 2008, by revelations about historic abuse in children's homes on the island of Jersey. There were also investigations in a number of other areas including Merseyside, Cheshire and London (Colton, 2002, Barter, 1998, Barter, 2003). These investigations uncovered evidence of serious and systematic abuse that had often continued over many years. In 2007 the Scottish Government set up an inquiry into abuse at Kerelaw residential school and secure unit, which had continued for around 25 years, but we are not aware of any other recent reports of abuse in children's residential care (Frizzell, 2009).

Most of the UK evidence on abuse in children's residential care comes from these inquiries. However, reliance on evidence from official inquiries is problematic, not least because most of these concern practices many years ago, prior to the introduction of safeguarding procedures and regulations which aim to prevent their recurrence. Another problem is that their findings are not drawn from representative samples of children's homes. While we know a great deal about the nature of the abuse that occurred in the institutions investigated we do not know how widespread it was. However, the fact that in many cases the abuse only came to light years after it occurred suggests that under-reporting, or a failure to take complaints seriously, may have given the impression that the abuse was less widespread than it actually was (Stein, 2006, Attar-Schwartz, 2011). If abuse does occur in children's homes today, we should be alert to the fact that it may not be reported while the children concerned are living in them.

Three UK studies in the 1990s included data on abuse in children's residential care but these had small or unrepresentative samples (Hobbs et al., 1999, Morris and Wheatley, 1994). Although these cannot tell us about the scale of the problem, they nevertheless indicate that a problem did exist, at least at the time they were conducted. In the early 1990s calls to the Childline helpline by 278 looked after children revealed that a small number were concerned about sexual abuse in their children's homes (Morris and Wheatley, 1994). A few reported sexual abuse by male residential staff (with 'kissing and touching' mentioned by way of illustration), accompanied by threats of physical abuse or a move to secure accommodation if they disclosed this to anyone. A study of 40 sexually abused or abusing young people in residential care in the mid-1990s noted one example of sexual abuse by a member of staff (Farmer and Pollock, 1998). However, a study of a representative sample of 48 children's homes in the same period,

which included interviews with 223 residents, uncovered no evidence of abuse by staff (Sinclair and Gibbs, 1998).

The above studies all cover a period before the implementation of measures to prevent abuse in residential care following the reviews of children's safeguards in England and Scotland (Kent, 1997, Utting, 1997). Recent studies of English children's homes have uncovered no evidence of abuse by staff and reported that residents were generally positive about the care they received (Berridge et al., 2008, Berridge et al., 2012, Berridge et al., 2011). Although none of these studies had a specific focus on abuse in care, all included interviews with residents. However, a recent report on calls to ChildLine by looked after children did note a small number of reports of assault or sexual abuse by staff, but commented that sexual abuse in residential care was not commonly cited by callers (Hutchinson, 2011).

There has been some research in other countries, particularly the USA, but the institutions concerned are located in very different welfare contexts and may differ from children's homes in the UK. For example, some studies include data on establishments for young offenders. The first comprehensive study of abuse in a wide range of residential and day care institutions in the USA, carried out in 1979, estimated that there were 39 allegations of abuse or neglect per 1,000 children in institutional care, while another American study reported that, on average, abuse was confirmed for around 1 per cent of more than 1,000 children in group homes in the state of Illinois over a five-year period (Rindfleisch and Rabb, 1984, Poertner et al., 1999). Variations in rates of reported abuse in different studies are likely to be due to variations in the definitions used: some focus exclusively on sexual or physical abuse, some include verbal aggression by staff, and some include all forms of abuse or neglect.

A recent self-report study of 1,324 adolescents in residential care in Israel included attention to verbal as well as physical abuse or neglect, but did not investigate sexual abuse. It found that 29 per cent reported verbal abuse or neglect (insults, curses, humiliation) and one-quarter had experienced physical abuse or neglect (including pinching, shoving, grabbing, kicking and slapping) (Attar-Schwartz, 2011) However, the children's homes in this Israeli study appeared to provide a very different environment to those in the UK, as they were large institutions with an average of 102 residents, whereas the average size of the resident group in English homes is six (Berridge et al., 2012). Although studies from other countries are of interest, their findings cannot be directly extrapolated to the UK due to important differences in the nature of the institutions investigated. There has never been any systematic research on abuse in children's homes in the UK, so we do not know whether abuse remains a problem in

children's homes today and if so, what the nature of any such abuse might be.

1.2.1 Recent concerns about residential care

Recent concerns have been shaped, to some extent, by changing expectations about the care of young people in residential institutions. Until the mid-twentieth century, the legacy of the old Poor Law institutions was evident in the frequent acceptance of harsh regimes and punitive treatment in residential institutions as 'normal' (Packman, 1975, Sen et al., 2008, Frost and Stein, 1989)1975, Sen et al., 2008, Frost and Stein, 1989. From the 1970s there was growing acknowledgement of child abuse in the wider community. Nevertheless, supposed treatments such as 'regression therapy' in some Leicestershire children's homes, the punitive Pindown regime in Staffordshire homes and the use of 'confrontational' physical restraint methods at the Aycliffe Centre were officially sanctioned and even publicly acclaimed, due to a misguided acceptance of their proponents' claims for their 'therapeutic' effects, or for their validity as methods of behaviour management. Stein has highlighted the ways in which the failure of managerial and inspection systems; the increasing marginalisation of residential care and the associated lack of purpose, low morale and understaffing in the sector left the door open to "abusers, many of whom were paedophiles and........to the peddlers of half-baked psychotherapy and crude behaviourism." (Stein, 2006 p.15).

A growing emphasis on the rights of children from the 1980s; the UK's adoption of the United Nations Convention on the Rights of the Child in 1991; the inquiries into abuse in residential care in the 1990s; the safeguarding measures introduced from the late 1990s and wider changes in child care policy all contributed to a shift in views about acceptable care. Young people's voices have also played a part in shaping the agenda: over 20 years ago, a report by the National Association of Young People in Care (NAYPIC) included the failure to provide a warm and caring environment in their definition of abusive care (Moss et al., 1990). Today there is an emphasis on safeguarding children, raising standards of practice, improving the quality of care and improving outcomes for looked after children (Department for Education, 2011a, Stein, 2009, Department for Education, 2011c). As a result of these shifts, recent concerns have been somewhat different to those in the past.

We have found no recent reports of abuse in residential care in the UK. However, there is some concern that physical restraint might sometimes be used excessively by residential staff, although there is no hard evidence on this. Given the history of its excessive use in children's homes in the past (for example in Leicestershire

and at the Aycliffe Centre) and a proper concern for the rights of children, physical restraint remains a sensitive issue. In a context where children's homes care for some of the most vulnerable young people in the population, many of whom have serious emotional and behavioural difficulties and some of whom are violent to others, the occasional use of physical restraint is officially sanctioned. However, it is allowed only in exceptional circumstances, to prevent injury to self or others, or damage to property (Department for Education, 2011b). These regulations specifically prohibit the use of restraint involving pain or excessive force. Recent research and consultation with looked after children suggests that they accept its use in certain circumstances, but that it should only be used as a last resort (Steckley, 2012, Children's Rights Director for England, 2012).

Other concerns appear to centre more on the behaviour of residents than that of adult caregivers. Both Utting's review of residential child care in England (Utting, 1991) and research reports in the 1990s noted that placement in residential care may expose young people to being abused by other residents. Studies reported that some residents sexually abused others (Morris and Wheatley, 1994, Sinclair and Gibbs, 1998), and that some had previously been victimised in this way themselves (Farmer and Pollock, 1998). Those who had become looked after due to past sexual abuse within their families (or sexual exploitation outside them) sometimes became a target for sexual abuse by peers within their children's home. Some of those who had reported sexual abuse by peers complained that this was not taken seriously, because staff sometimes viewed this as consensual sexual activity (Farmer and Pollock, 1998, Morris and Wheatley, 1994). Several studies have also found evidence of widespread bullying in residential care, often persisting over long periods (Whitaker et al., 1998, Farmer and Pollock, 1998, Wade et al., 1998). In one study of 48 children's homes 40 per cent of the young people reported being bullied by other residents (Sinclair and Gibbs, 1998). A recent study of 27 children's homes found that nearly half of a small group of residents whose placements had disrupted had been obliged to leave because they had violently assaulted other residents or staff (Berridge et al., 2011). Homes in which these behaviours occur may not have abusive regimes but may nevertheless be abusive environments in which to live. This has also been noted in the USA, with one large study reporting that abuse was confirmed for 12 per cent of all children in residential homes, but in 70 per cent of cases the perpetrators were other residents (Spencer and Knudsen, 1992).

Currently, sexual abuse by adults external to the placements appears to be the greatest concern. Children's homes are typically open environments nowadays, but this can make it harder to protect residents from abusive adults outside them. In the context of the current safeguarding measures, it is possible that predatory men might

now seek access to children in other ways than through employment in a children's home (Berridge et al., 2014). Although vulnerable young people who are not looked after are also sexually exploited, some young people in children's homes may be exposed to this by virtue of being in residential care, because their placement makes them an identifiable target and exposes them to coercion by peers. (Wade et al., 1998, Biehal and Wade, 2000, Farmer and Pollock, 1998, Wild, 1989, Jago et al., 2011, Dillane et al., 2005). Sexual exploitation is often closely linked to going missing from care. Some residents who go missing become exposed to the risk of sexual exploitation while out on the streets, while others go missing as a result of being drawn into sexual exploitation. Residential staff often struggle to prevent residents going missing and to protect them from sexual exploitation (Wade et al., 1998, Wade, 2002, Jago et al., 2011). Going missing from residential institutions, such as the former Approved Schools and Community Homes with Education, was a recurring focus of concern throughout the post-war period. Interestingly, there was a flurry of research into high rates of going missing in the 1970s, a period in which, it subsequently emerged, serious abuse was occurring in a number of institutions (some of which were included in these studies) (Wade et al., 1998).

Finally, there is growing concern about whether the nature of modern residential provision puts young people at risk of poor quality care or harm, although concerns about the quality of residential care have existed for many years (Packman 1975; Utting, 1991; Waterhouse, 2000). In 2011–2012 over half (60 per cent) of children were placed in homes provided by the private or voluntary sector (mainly the private sector) and one-third over 20 miles from their local communities, limiting the degree of supervision and support that could be provided by their social workers (Department for Education, 2012c). Children may be placed outside their home area due to a lack of capacity within their local authority, although in some cases there are good reasons for placing them at some distance from harmful adult or peer contacts (Biehal and Wade, 2000). Local authorities to which children from other areas move to enter placements in private and voluntary sector homes are often unaware of the presence of these children, and until recently police have been unaware of the presence of these homes in their area (see below for current government plans to address these issues). This has led to a gap in the protection of vulnerable children from sexual exploitation and other harm from adults external to the placement. We do not know, however, whether they are also at risk of harm from adult caregivers within residential placements, nor how much staff are themselves at risk of unfounded allegations of abuse.

1.3 What is known about abuse or neglect in foster care?

Virtually all of the UK evidence on the extent of abuse or neglect in foster care comes from inquiry reports on individual cases or from studies that report briefly on the issue of abuse by foster carers in the context of wider studies of foster care. The only systematic investigation of the extent of confirmed abuse or neglect by foster carers remains a single survey of 59 social work agencies. This was conducted in the mid-1990s and had a low response rate, limiting its usefulness today (Nixon and Verity, 1996). There is also very little information available on the *nature* of abuse or neglect in foster care.

The first documented case of abuse in foster care was that of Denis O'Neill, who died in 1945 as a result of abuse by his foster father. Since then there have been a number of inquiries into abuse in foster care, including the inquiries into the deaths of Shirley Woodcock (1984), Chelsey Essex (2007), and into cases where foster carers have been imprisoned for the abuse of foster children, including Eunice Spry, Kenneth Norton and two foster carers in Wakefield who sexually abused a succession of foster children (Parrott et al., 2007). More recently the report of a court case, *A and S (Children) v Lancashire County Council [2012]*, documented the physical abuse of two siblings in two of the many foster placements they had lived in over an 11-year period (Conroy, 2012).

The Edinburgh Inquiry warned of the danger of over-optimism about the quality of care provided by foster carers who are well known to social workers (Marshall et al., 1999). This warning was later borne out by the Reading Serious Case Review into the physical abuse of a baby, which suggested that the fact that the foster carers concerned were well known to local social workers hindered the objective assessment of their strengths and weaknesses, despite the fact that these carers had repeatedly failed to report a number of minor injuries to previous foster children (Reading Local Safeguarding Children Board, 2011). The Utting report on safeguards for children living away from home warned that there had been a number of cases "where carers had won considerable confidence and respect but where this has masked abuse." (Utting, 1997 p.38). The Wakefield Inquiry revealed that professionals avoided facing up to the implications of the concerns raised about the behaviour of two foster carers, in this case partly due to fear of stigmatising gay carers and partly because they were intimidated by them (Parrott et al., 2007). Both the Wakefield Inquiry and the Reading Serious Case Review highlighted serious professional and systemic failures that allowed the abuse to continue.

There has been some discussion of the difficulty of either confirming or refuting many allegations in foster care (for example Cavara and Ogren, 1983 in the USA, Carbino, 1992, Rosenthal et al., 1991), with the result that foster carers may remain under suspicion and children may be removed unnecessarily. On the other hand, the Utting report noted that enquiries into abuse or neglect in foster care often uncover a background of previous allegations that have not been taken seriously and emphasised the importance of recording all allegations investigated on the foster carer's file (Utting, 1997). This has also been noted by researchers in the USA (Cavara and Ogren, 1983). Utting considered that the isolation of foster care meant that social workers should visit regularly and always spend some time alone with children. Research in America supports this view, as one study found that 25 per cent of foster carers investigated had been the subject of previous, often multiple, allegations (DePanfilis and Girvin, 2005).

1.3.1 The extent of abuse or neglect in foster care

It is important to distinguish between the number of allegations and the number of cases in which abuse or neglect is substantiated. However, only two studies (one in England and one in Scotland) have addressed this issue and both were conducted nearly 20 years ago. Just over one-fifth of the allegations reported in the English study were confirmed, while the Scottish study noted that 16 per cent of the foster carers involved in allegations were subsequently deregistered, amounting to 0.56 per cent of all foster carers (Triseliotis et al., 2000, Nixon and Verity, 1996). The two studies are not strictly comparable, as the Scottish study only reported cases of deregistration; not the potentially wider group of confirmed cases that did not result in deregistration.

The English study reported that children in long-term foster care were exceptionally vulnerable due to the more limited oversight of these placements, but did not find that abuse in long-term foster care was widespread. Both of these studies found that the alleged abuse was confirmed for less than 1 per cent of the foster homes. However, an English study of 270 kinship and unrelated foster placements reported that 'well-founded' allegations had been made against 4 per cent of foster carers (Farmer and Moyers, 2008). Official data are of limited value in this respect. Although the annual Ofsted report on fostering services reports the number of foster carers who experience allegations each year, it does not tell us the proportion of allegations that are eventually substantiated.

Another gap in the research is that most UK surveys have taken foster carers, rather than children, as their focus of analysis. The small number of UK studies that *have* provided data in relation to children have reported on their experience throughout the time they have been looked after. One English study of 596 fostered children noted that abuse or neglect in foster care had been confirmed for 3 per cent of these children at some point in time, but there was considerable variation in the length of time they had been fostered (Sinclair et al., 2005a). However, there have been no previous UK studies of the *incidence* of confirmed abuse or neglect in foster care – i.e. the number of children whose abuse or neglect has been confirmed in a specific period of time.

All previous (English-language) research on the incidence of abuse or neglect in foster care has come from the USA. Evidence from American studies indicates that in that country, between 0.27 and 2 per cent of children may experience abuse or neglect in foster care in a single year (Poertner et al., 1999, Spencer and Knudsen, 1992, Billings and Moore, 2004, Bolton et al., 1981, California Department Of Social Services, 2001). The variation in findings from studies conducted in different American states indicates that there is likely to be some local variation in thresholds for investigating or confirming abuse. Such differences are likely to be even greater between countries, so we cannot assume that the annual rate of substantiated abuse or neglect in foster care in the UK will be the same as in the USA.

1.3.2 Recognition of abuse or neglect in foster care

Some studies raise the important point that, following investigation, allegations of abuse or neglect may not simply be categorised as either substantiated or unfounded, as investigations typically find that some allegations fall into a category termed 'unproven' or 'inconclusive.' For example, an English study and an American study both reported that in around 20 per cent of investigations into allegations the results were inconclusive (Nixon and Verity, 1996, California Department Of Social Services, 2001). Another two studies reported inconclusive findings in a much higher proportion of investigations. The paediatricians who conducted an English study of 157 incidents of possible abuse in care classified just one-quarter of incidents as 'confirmed' and the remaining 75 per cent as 'suspected' or 'probable' (Hobbs et al., 1999).

An American study found that over half of all allegations of physical and sexual abuse were 'unable to be substantiated' and over one-third of investigations into neglect were inconclusive possibly, it argued, because neglect is particularly difficult to substantiate in the absence of physical evidence (Rosenthal et al., 1991). This study reported that

social workers were reluctant to classify allegations as 'substantiated' without irrefutable evidence, and considered that the true rate of actual abuse or neglect was higher than indicated solely by the number of cases classified as substantiated. They argued that carers for whom allegations are unsubstantiated should be closely monitored, particularly as 27 per cent of the families involved had previously been investigated for abuse or neglect.

1.3.3 The nature of the abuse or neglect

Few studies provide details of the nature of confirmed abuse or neglect in foster care. A study of 388 children in foster care in one Australian state reported that that the majority of confirmed reports of abuse or neglect by foster carers were related to carers coping poorly with children's relationship and behavioural disturbances. These incidents typically involved inappropriate discipline or scapegoating, ranging from smacking to serious emotional and physical harm. A smaller group of children in this study endured "neglectful, abusive or predatory care which was not attributed to poor coping by distressed carers." (Tarren-Sweeney, 2008: 9). This smaller group of carers were described as having emotional, personality or relationship difficulties incompatible with fostering. This is corroborated by two reports on calls to ChildLline by looked after children. These include the accounts of a small number of fostered children who described being hit or emotionally abused by their foster carers (Hutchinson, 2011, Morris and Wheatley, 1994). Interviews with fostered children and their carers in a recent English study similarly revealed that several had been maltreated by previous foster carers. For most of these 10 children the abuse or neglect had been serious, including practices such as keeping a disabled child locked in her bedroom, forcing a child to have cold showers and then stand shivering in the garden, hitting children, forcing them to sleep on the floor in filthy conditions, beating them and denying them food (Biehal et al., 2009).

Other studies have concluded that the majority of incidents reported concerns about unacceptably poor standards of care by foster carers rather than abuse as such (Sinclair et al., 2005a)(Triseliotis et al., 2000: 104). Much depends, of course, on the threshold for defining behaviours as abusive, rather than as evidence of poor standards of care. In some cases the boundary between poor practice by foster carers, which might potentially be addressed through the provision of support and guidance, and actual abuse is unclear. These definitional difficulties reflect the wider issue of variations in thresholds for defining behaviour as abusive or neglectful in any context.

There is some concern about physical restraint in foster care, although this is allowed in certain circumstances. Ofsted defines acceptable restraint as stopping a child or young person "from doing something they want to do by physical means. For example, the foster carer moving the child/young person or blocking their movement to stop them hurting themselves or others from seriously damaging property." (Ofsted, 2012 p.10). Ofsted reported that during the year 2011, 596 foster carers and 554 foster children in England were involved in 1,247 reported incidents of physical restraint (two-thirds of which were recorded by foster carers in independent fostering services). However, we do not know whether this restraint was judged to be excessive in any of these cases, nor about the circumstances in which it occurred.

1.4 Comparisons with children in the community

A few studies have compared the extent of abuse or neglect in foster or residential care to that of abuse or neglect within families or in other care settings. A recent school-based survey in Finland compared reports of psychological aggression and physical violence by adult caregivers from 233 12–16 year olds who had ever lived in care to those from over 13,000 other young people living with their parents. The definition of abuse used was quite wide, including: refusing to talk, criticizing, name calling or threats of violence from adult caregivers as well pushing, shaking, slapping or hitting. Children in care were significantly less likely to report psychological aggression and physical violence than children living at home. Overall, 20 per cent of children living with parents reported physical violence of some kind, compared to 12 per cent of children in care (Ellonen and Pösö, 2011). However, the Finnish care system may differ from our own, making it difficult to directly extrapolate these results to a UK context.

Two American studies found a higher rate of *alleged* abuse or neglect by foster carers compared to parents (Bolton et al., 1981, Benedict et al., 1994). Another American study found that the rate of confirmed abuse by foster carers was slightly higher (1.7 per cent compared to 1.1 per cent for parents), but that children were less likely to experience neglect in foster care than in their own families. Children in residential care were far more likely to experience abuse than those living with their parents, but a high proportion of this abuse was perpetrated by other residents in the residential homes (Spencer and Knudsen, 1992).

It is possible that the risk of abuse or neglect is indeed higher in foster care, although there is no evidence whether this is the case or not. Some carers may respond poorly to challenging behaviour of children with high levels of need, perhaps using overly punitive discipline (Morris and Wheatley, 1994, Bolton et al., 1981, Mc Fadden and Ryan, 1991, Tarren-Sweeney, 2008). In other cases, carers may not show warmth or care (Selwyn et al., 2006, Morris and Wheatley,

1994, Biehal et al., 2010). On the other hand, some children may make unfounded allegations in the hope that this will lead to a return home, or because they feel a sense of divided loyalties. Some parents may also make unfounded allegations against carers, perhaps in the hope that this will lead to the children's return. Furthermore, if abuse or neglect does occur it might be more likely to come to the attention of the authorities: fostered children and their carers are under the supervision of professionals and thus under greater surveillance than most families in the community, which may increase the likelihood that abuse or neglect is detected.

However, some reports have suggested that the opposite might occur. Two American studies found a reluctance on the part of social workers to classify allegations as 'substantiated' and concluded that the true incidence of abuse or neglect in foster care was higher than the rate indicated by social worker reports (DePanfilis and Girvin, 2005, Rosenthal et al., 1991). One of these considered that the quality of investigations was undermined by the heavy workloads of the staff responsible, and by workers who avoided facing up to the seriousness of the concerns reported because no other placement was available for the child. They also pointed to the perceptual blocks of some social workers, who appeared to be prepared to accept the negative treatment of children, especially when those children were placed in kinship care (DePanfilis and Girvin, 2005).

From the limited evidence currently available, it is not possible to tell whether the apparently higher rates of allegations or confirmed abuse or neglect in foster care reflect a real difference in the extent of actual abuse in different settings, or simply differences between settings in the level of reporting of abuse or neglect. Although there might be over-reporting of unfounded allegations, actual abuse or neglect is possibly under-reported.

1.5 The policy context

Concern about allegations of abuse or neglect made against those working with or caring for children living away from their birth families has therefore been a longstanding issue reaching back over many years, especially with respect to residential settings. The development of policies, procedures and guidance for dealing with these allegations in a manner that can provide effective protection for children has been considerably more recent. While the establishment of devolved administrations in Wales, Northern Ireland and Scotland have led to different practical arrangements for safeguarding children, the core principles that underpin practice with respect to the management of allegations are similar.

The first guidance on the management of allegations concerning the abuse of children in England that reached across the whole children's workforce (rather than just education personnel) came with the 2006 publication *Working Together to Safeguard Children*, which was reinforced by the publication of largely equivalent guidance in other UK countries (HM Government, 2006).[1] Implementation was reinforced through strategies to embed effective procedures for managing allegations and sharing information in social care, education and health settings, and to establish safe recruitment policies and practice. Revised *Working Together* guidance has been published in 2010 and 2013.[2]

A government review of existing guidance on allegations in England reinforced the key role of Local Safeguarding Children's Boards (LSCBs) in establishing inter-agency procedures for dealing with allegations against people who work with children and for monitoring their effectiveness. It emphasised the need for every local authority to have a designated officer to manage and have oversight of all allegations, and to liaise with LSCBs (Department for Children Schools and Families, 2009). Each country within the UK has designated officers with these safeguarding responsibilities. In England, they have become known as Local Authority Designated Officers (LADOs) and they receive all allegations concerning those working with or (in the case of foster carers) caring for vulnerable children (and adults).

If it is alleged that such a person has acted in a way that has harmed or may have harmed a child, the employer should promptly report it to the LADO (or equivalent officer) for further consideration. Some will be so serious as to warrant immediate police investigation. Others may be considered by the LADO (or equivalent officer) in consultation with employers, the police (where appropriate) and other involved agencies to establish whether there is a foundation to an allegation and to determine an appropriate course of action. The general procedures for managing allegations in a timely and effective way are set out in Appendix 5 of *Working Together* 2010 (Department for Children Schools and Families, 2010). Broadly similar procedures relating to allegations arising in foster and residential care have also been developed in other UK countries (The Scottish Government, 2013, SIRCC and the Scottish Government, 2011, The Welsh Assembly Government, 2011).

1 In Wales, see: The Welsh Assembly Government (2006) *Safeguarding Children: Working Together under the Children Act 2004.* In Scotland, early government guidance issued in 1998 was subsequently replaced by The Scottish Government (2010) *National Guidance for Child Protection in Scotland,* with reference to interim arrangements for managing allegations published in the same year.

2 For the latest version, see: www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children.

The procedures for dealing with allegations are also reinforced in documents setting out national minimum standards for fostering and residential services in England (Department for Education, 2011c, Department for Education, 2011a).[3] Any allegations of abuse or neglect must be promptly referred to the area authority and a written record must be made of both the allegations and the action taken in response. The standards for fostering services emphasise the importance of providing independent support for foster carers who become subject to allegations, for them to be kept informed of the progress and outcomes of any inquiries, and to ensure that a demarcation is maintained between investigations into allegations of harm and those into the standards of care provided (Department for Education, 2011c). However, research reports drawing on foster carers' perceptions of the process suggest that it is where these standards continue to be lacking, in practice, that foster carers experience greatest frustration (Swain, 2006b, Wade et al., 2011b).

A number of outcomes of these investigations are possible. Some cases, where allegations prove to be unfounded or where evidence is insufficient, may result in no further action being taken. Alternatively, the behaviour or actions that led to the allegation may be corrected through the provision of further advice, training and support. Where there is cause to suspect that a child is at risk of significant harm, or where an allegation warrants investigation by the police, consideration should be given to the suspension of staff from contact with children while the investigation proceeds (Department for Children Schools and Families, 2010, see Appendix 5). In foster care settings, these considerations may involve the removal of the child (and perhaps other looked after children) from the placement. At the more extreme end, investigations may lead to the dismissal of staff or, for foster carers, to the termination of their approval to foster. Where an investigation leads to dismissal (or termination) or would have done if the person concerned had not already resigned, agencies must refer these individuals to the Disclosure and Barring Service.

The Safeguarding Vulnerable Groups Act 2006 made provision in England for a new vetting and barring scheme to assist agencies to develop safe recruitment practices and to provide for the disbarment of individuals from engaging in regulated work with children or vulnerable adults.[4] The Disclosure and Barring Service (DBS) has consolidated and replaced earlier regulatory agencies such as the Criminal Records Bureau and the Independent Safeguarding Authority (ISA), which in turn had replaced the old POCA lists and

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3 These minimum standards are issued under s.23 of the *Care Standards Act 2002* and underpinned by the *Children Act 1989 Guidance and Regulations Volume 4*.

4 Similar provisions, arising from the Protection of Vulnerable Groups (Scotland) Act 2007, have led to the development of a parallel agency called Disclosure Scotland.

List99 arrangements.[5] However, at the time data were collected for the current study, the ISA was still the main referral agency in use.

In England, Independent Reviewing Officers (IROs), who have an independent monitoring role, also play a part in safeguarding looked after children. Their role is governed by the *Care Planning Regulations* (Department for Education, 2012a). These regulations also include a requirement for responsible authorities to notify area authorities where out-of-authority children's homes are located. In 2014 concerns about looked after children placed in out-of-authority children's homes led the government to amend the Children's Homes Regulations in an attempt to improve the safeguarding of these children. Local authorities using out-of-authority residential placements must now inform the local authority in which the home is located of the admission or discharge of a child in their care. In the same year changes to the Care Standards Act introduced the requirement for applicants wishing to register a new children's home to ensure that the home is appropriately located, to reduce the risk that they will be targeted by predatory adults. Other planned changes will allow Ofsted will refuse to let new homes open in areas deemed unsafe and existing homes in unsafe areas will face closure if they cannot demonstrate that they can protect children. The aim of these measures is to ensure effective information sharing to reduce the risk that children in out-of-authority residential placements are targeted for sexual exploitation by adults external to the placement.

Taken together, these arrangements provide a framework for operating the allegations process as it relates to looked after children placed in foster and residential care across the UK. The description has been brief and is not considered to be exhaustive. However, it does provide some context to the empirical chapters that follow. As is the case with most areas of local authority practice, the implementation of regulations and guidance is likely to be variable and the chapters that follow will highlight, where appropriate, the scale and nature of this variation as it affects allegations concerning the mistreatment of looked after children.

1.6 Conclusion

The care system generally provides a safe environment for children, and many children and young people say that they think that their care is good (see, for example, Wade et al., 2011a, Biehal et al., 2010). Despite the efforts of social workers and other professionals to remove children from abusive environments, there is nevertheless a

5 For information about the DBS, see: www.gov.uk/government/organisations/disclosure-and-barring-service/about. For information about Disclosure Scotland, see: www.disclosurescotland.co.uk/about/.

risk that they may inadvertently place them at risk of abuse or neglect *within* the care system. We know a little about the sexual exploitation of looked after children by adults external to the placement, about abuse during contact with family members and about physical and sexual abuse between peers (Farmer and Pollock, 1998; Barter, 2003; Sinclair et al, 2005). We also know quite a lot about historic abuse in residential care. However, we know very little about the extent and nature of abuse or neglect by adult caregivers in foster and residential care today. This is the focus of this study. Only by understanding the nature of the problem can we address it. Understanding more about allegations and confirmed abuse or neglect is critical to supporting and protecting both looked after children and those caregivers who are the subject of unfounded allegations.

Chapter 2

Study design and methods

Very little is currently known in the UK about the extent and nature of abuse or neglect of looked after children by those adults charged with their care. This study builds upon earlier exploratory and pilot work by our research team, including a review of international research literature and a short feasibility study to test the viability of conducting further research (Biehal and Parry, 2010). These provided a framework for the current investigation into allegations and confirmed cases of abuse or neglect of looked after children and young people.

The study was designed in two phases:

- Phase 1 involved a brief survey of all local authorities across the UK to provide the first reliable estimates of the scale, characteristics and outcomes of allegations concerning looked after children.
- Phase 2 involved a more detailed follow-up survey of confirmed cases of abuse or neglect in foster and residential care in 24 local authorities.

The research was funded by the NSPCC, and conducted by the Social Policy Research Unit at the University of York, in partnership with the Fostering Network.

2.1 Research aims

The study covered a period of three years (1 April 2009 to 31 March 2012). The purpose of the study was to provide new empirical evidence on:

- The incidence of allegations of abuse or neglect; the proportion of allegations that are (after investigation) found to be substantiated, unsubstantiated (due to insufficient evidence) or unfounded, and the outcomes of these allegations for the children and adults concerned.
- The characteristics of children and adults involved in confirmed cases of abuse or neglect in foster and residential settings.
- The main features of incidents of abuse or neglect, including information on the different settings in which it occurs, the range of behaviours or actions concerned and the implications of these for the future safeguarding of looked after children.

This mapping study, undertaken between July 2012 and June 2013, represents the first step in a modular programme of research that, subject to funding, will utilise quantitative and qualitative methods to provide a comprehensive understanding of the scale of the problem; of how and why allegations arise; of the course and outcomes of investigations, and of the shorter- and longer-term implications these have for children and for the adults involved.

2.2 Study design

As indicated in Chapter 1, few studies had previously looked at this question, and research evidence to inform the current design was therefore limited. Furthermore, from a policy and practice perspective, it was unclear how local authorities responded to allegations: whether their procedures were in any way consistent, or how allegations were recorded and/or collated by them to provide the aggregate statistics we needed. For example, while the responsibility for investigating allegations in England rests with Local Authority Designated Officers (LADOs), this was not the case for other countries in the UK. We therefore needed to find out how allegations concerning looked after children in Wales, Scotland and Northern Ireland were managed. Equally, while English local authorities have a duty to report allegations annually to Ofsted, it was not clear whether similar reporting requirements existed in other countries, or whether English authorities were able to report allegations accurately, drawing on data held centrally, or whether a manual trawl of files was needed to provide aggregate data.

For these reasons we adopted an exploratory approach, based on our initial feasibility study, and the design went through several iterations as new information came to light about different roles and responsibilities; the management of different kinds of cases (for example, concerning children placed inside or outside the local authority); the different ways in which information was held; the kinds of questions that could be answered from the data available, and about the willingness of local authorities to engage with the study and provide the information we needed. This process is considered further below.

Phase 1: The UK survey

The UK survey involved the collection of summary data on every allegation referred to a LADO (or equivalent officer responsible for safeguarding looked after children) during our designated survey period (2009–2012). One limitation of the study, therefore, is that it cannot take account of allegations that were not referred through these channels for whatever reason. The use of this yardstick, however, meant that the study would have a clear focus on allegations that were considered sufficiently serious to warrant further formal investigation.

Furthermore, LADOs are concerned with allegations made against adults working with children. In consequence, the study cannot capture incidents where the subject of the allegation was another child.

This phase was intended to include every local authority in all four countries and to include all incidents that had occurred in foster or residential placements. As such, incidents that had taken place while children were away from placements or visiting their birth families were excluded. Our focus was placement-centred.

A Freedom of Information request was made to each local authority. The Freedom of Information Act 2000 gives any member of the public the right to ask public sector organisations for any recorded information they have on a specific subject.[6] These organisations then have 20 working days to provide this information. If the organisation requires more time they should inform applicants when they can expect to receive a response. There are some exemptions. For example, where provision of information could lead to the identification of individuals; where the cost of collecting it would exceed £450; or where the data are not available, organisations can reasonably refuse the request. They must provide written reasons for doing so and you may ask for the decision to be reviewed. If not satisfied with the response, you can then have recourse to the Information Commissioner.

The adoption of this strategy meant that the information request needed to be both clear and brief. For each of the three years local authorities were asked to provide the following data separately for foster and residential placements:

- the total number of allegations of abuse or neglect of children
- the number of allegations that were substantiated
- the number that were unsubstantiated and, of these, the number that were proved to be unfounded or unsubstantiated due to insufficient evidence
- the number of substantiated, unfounded and unsubstantiated allegations that resulted in the permanent removal of the child from the placement.

In total, information was provided by 156 of the 211 local authorities that had been approached: an overall response rate of 74 per cent. Forty-six local authorities (22 per cent) refused to comply with our request and a further nine failed to acknowledge our initial

6 The Freedom of Information (Scotland) Act 2002 provides for a broadly similar framework in Scotland.

communication. Some variation in response by country was apparent.[7] These country variations were largely explained by the degree to which local authorities routinely collected and maintained electronic records of allegations on their information systems. Local authorities vary in size, and specifically in the number of children they have in care at any one time. However, there was no significant difference in the size of local authorities which did and did not participate in the UK survey, in terms of the total number of looked after children in 2011–12.[8] We can therefore be confident that the survey findings are reasonably representative of the spread of local authorities across the UK.

Reasons for refusal were broadly in line with the exemptions provided in legislation. Most refusals were on grounds of time and cost. As indicated above, some refused or were unable to provide any data at all. Others were able to answer certain questions, but not others. First, non-compliance was highly likely where no central electronic records were held and the estimated cost of a manual search was assessed as exceeding the appropriate limit prescribed in fees regulations. One local authority had estimated the cost of a manual search of files and of minutes of panel and safeguarding meetings at £1,587. In addition, some local authorities had only more recently updated their recording systems and could not provide data for earlier years.

Second, local authorities were more likely to return partial information where there was no obvious correspondence between electronic records held on adults and children. LADOs (or equivalent officers) are primarily concerned with adults accused of abuse or neglect (and do not always retain data on the children involved or the outcomes for them), while social care records are child-centred (and do not generally contain information on foster carers and residential workers who may be the subject of allegations). In many areas, therefore, no single data source will exist unless these datasets are cross-referenced. Given the significance of the issues at stake here, the development of a single and comprehensive dataset concerning allegations should be a priority for local authorities. Otherwise, it is difficult to see how an authority can develop an overview of the problem at local level,

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7 Response rates varied by country – England (77.6 per cent), Wales (81.8 per cent), Scotland (59.4 per cent) and only one out of five (20.0 per cent) of the Health and Social Care Trusts in Northern Ireland were able to provide the data requested, at least within the timescale of the study. This difference was statistically significant (Cramer's V = 0.247, p=0.05). However, if Northern Ireland is excluded, there was no longer a statistically significant difference in response rate between England, Scotland and Wales (Cramer's V = 0.160, p = 0.071).

8 An independent-samples t-test was conducted and there was no significant difference in size (in terms of total number of looked after children) between respondent local authorities (M=413, SD=316) and non-respondents (M=495, SD=514); t(219)=1.4, p=0.16.

develop appropriate strategies to limit the risk of abuse or neglect of children in their care or manage the allegations process and its consequences for all concerned more effectively.

Third, a small number of local authorities were concerned about data protection and the risk that the identities of individuals might be revealed. These concerns are of obvious importance, especially since the results of Freedom of Information requests are in the public domain and local authorities have to comply if the same information is requested by another person. The Act allows for exemptions in these circumstances. This was most likely to occur where the number of substantiated allegations in an area was very low. In these circumstances, some returns only specified, for example, 'fewer than five'. All of these decisions were challenged on the grounds that we needed precise numbers and that our study would do no more than aggregate these to provide an overview of substantiated allegations. As such, no personally identifiable information was being collected within the meaning of the Data Protection Act 1998. In some instances, the initial decision was reviewed in our favour, in others not.

Phase 2: Investigating confirmed abuse or neglect

The purpose of Phase 2 was to provide more detailed follow-up information on confirmed cases of abuse or neglect. All local authorities that completed a Phase 1 return (and reported the existence of substantiated allegations) were invited to take part in Phase 2. In addition, a small number of local authorities that had not completed a Phase 1 return at that stage were also invited to take part.

2.2.1 Local authority recruitment

In total, 138 local authorities were approached via email to the Head of Service for looked after children in each area. These emails set out the purpose of Phase 2, what we would require them to do and provided evidence of the ethical approvals obtained from University of York and, of relevance to English authorities only, from the Association of Directors of Children's Services (ADCS). Of these 138 authorities, 74 (54 per cent) failed to respond to our request, 24 (17 per cent) explicitly refused to participate, and 40 (29 per cent) agreed in principle. Our recruitment strategy involved several (sometimes overlapping) steps:

1. Formal approval, with email confirmation, was obtained from Head of Service and they provided the details of senior fostering and residential managers who could assist us with data collection.
2. These managers were then approached (often in consultation with LADOs that had taken part in Phase 1) to ask for the basic data we needed to recruit our Phase 2 sample and the contact details of relevant fostering and residential social workers who

knew each case and could complete our questionnaires. For each substantiated allegation in each area, therefore, we obtained the following information: child ID; approximate date of birth (month/year); sex; date of allegation; type of placement, and placement ID (however this was recorded). This was the minimum needed to ensure that we would be communicating about the correct child and placement.

3. Before sending out questionnaires, each foster/residential worker received an email to give them advance warning, explain the task and provide an opportunity for queries to be resolved. A further email then provided a unique link to the secure online questionnaire for each case with certain details, including date of allegation, gender and month/year of birth of child, pre-inserted to allow workers to identify the case.

4. A considerable number of placements were located in the independent sector. Where the name and contact details of the agency were provided, the Head of Agency was approached directly for cooperation. Where details were not obtainable or no response was received from the agency, the relevant LADO was approached to complete a shortened version of the questionnaire as best they could from the data available to them. This strategy also helped to alleviate the worry that some independent agencies may be reluctant to participate due to their commercial concerns or interests – not that we had evidence that this was so.

At each step local authorities had an opportunity to withdraw from the process and some chose to do so. Of the 40 that initially agreed to take part, 24 finally returned completed questionnaires. A majority were from English local authorities (16); six were from Welsh and two were from Scottish authorities. No returns were received from Northern Ireland.

Of these 24 local authorities, 23 were able to provide information on foster placements. Out of 159 fostering questionnaires that were sent out, 87 completed questionnaires (55 per cent) were returned, concerning 118 children.

With respect to residential provision the potential pool was smaller, as some local authorities either had no residential provision or, if they did, no substantiated allegations to report. Phase 2 questionnaires were eventually received from eight of these 24 local authorities, including one that had not provided fostering data. Sixty residential questionnaires were sent out and, of these, completed questionnaires on 24 allegations (40 per cent) accounting for 28 children had been returned by the survey deadline (31 March 2013). To improve the response rates, three email reminders were posted at weekly intervals in an effort to prevent our questionnaire request from slipping down the in-tray of social workers.

Overall, therefore, the Phase 2 survey comprises information on 111 allegations concerning 146 children. It is not possible to say to what extent these patterns of return may have influenced the nature of our final sample. Unfortunately we do not have further information on non-return cases that would enable us to tease out whether there are any systematic differences between the respondent and non-respondent samples. Since this study is descriptive analytic in approach and represents a first exploration of the issues surrounding allegations, this may not be as serious a problem as would be the case for studies adopting more experimental or comparative methods.

As we will see further in later chapters, there was considerable variation in the numbers of allegations reported by different local authorities and these may, at least in part, reflect not just differences in local demographics but also in definitional thresholds for intervention (what behaviours or actions are considered serious enough to warrant investigation). Since most local authorities knew in advance (from their Phase 1 returns) how many substantiated allegations would be followed up in their area, it was noticeable that those with higher numbers tended to express greater reluctance to take part, out of concern for the time and resources that participation might involve. Some compromises therefore needed to be made to prevent their complete withdrawal. For example, some local authorities agreed to provide questionnaires for cases that had arisen in the last year only (or in the last two years if this was more appropriate). This was also the case where LADOs had been asked to complete shorter multiple questionnaires for children placed in the independent sector where this information could not be provided directly by the agency. Some information was better than none and taking a cross-section of cases from a single year meant that a strong element of randomisation was retained.

2.2.2 Data collection

Data for the online survey was collected using SNAP software. SNAP provides a secure method for transferring survey data; the server itself is located within the UK (rather than overseas) and information entered through SNAP is directly transferrable to the statistical analysis software package SPSS.

Two versions of the questionnaire were developed and piloted, one for foster care and one for residential care. The gestation period was lengthy. Lack of previous research in this area meant that the survey design was subject to gradual organic development. The variability that was discovered in record-keeping systems, in different role responsibilities between local authorities and in identifying who could broker the study on our behalf and who was best placed to provide

the layers of information we needed at each stage all contributed to this complexity.

Apart from the challenge of framing accurate questions that were in line with the information respondents actually held, a further difficulty arose from the nature of an allegation itself. Allegations may concern a single child or several children in the same placement. If the questionnaire was child-focused, the same worker would be required to laboriously complete several questionnaires about what was fundamentally the same incident. This request would be unreasonable. We therefore adopted an allegation focus (in line with how LADOs record their data), so that one questionnaire was completed for each allegation but in a way that could take account of several children. Fortunately SNAP could cope with this and questions were framed so that key information could be collected for each child involved. After all, not all children are affected in the same way and not all necessarily share the same outcome.

A further issue of definition arose as our understanding of the management of allegations developed. This concerned differences for children placed within the boundary of the responsible local authority and those placed outside it. In general terms, an allegation concerning a London child placed, for example, in the north of England would be managed by the host authority. However, the extent to which the home authority would be kept informed and would maintain records of the progress of this allegation appeared to be highly variable. In another example, the management of allegations between London local authorities was sometimes uncertain or overlapping. Where foster carers were employed by one local authority but were based in another, there was some variability in which local authority took the lead on investigations: As a result of these uncertainties, a decision was made to focus the survey on all children resident within the local authority that had agreed to participate in the study, even where these children had been placed there by another local authority. As an overall finding, however, there is a need to focus attention on the relationship between local authorities where the abuse or neglect of looked after children is suspected. Clear structures and communication strategies are needed to ensure that the management of allegations is effective and that care planning for the child does not suffer. These relationships should also form a focus for future research studies in this area.

The foster and residential questionnaires covered the same ground and the content was broadly as follows:

- placement (type, location, provider, duration, distance from home area)
- foster carer relationship to the child(ren)

- local authority responsible for child(ren)
- characteristics of person(s) who was/were the subject of the allegation
- characteristics of each child involved (gender, ethnic origin, disabilities)
- what behaviours or actions prompted the allegation (open-ended and categorised for each child)
- the outcome of the allegation for the child(ren) – whether or not removed from placement temporarily or permanently
- the outcomes for other children resident in placement
- the outcome of the allegation for residential staff or foster carer(s)
- aspects of fostering history of foster carers (duration, approval range, previous allegations)
- whether the child(ren) had made previous allegations in this or earlier placements
- aspects of the care history of each child (duration, number of episodes, main reasons for first and last care entry)
- reflective question on why and how this allegation occurred and any lessons that can be learnt from this case.

The Phase 2 survey was conducted between January and March 2013 to leave sufficient time for data preparation, analysis and completion of a draft final report for the end of June.

2.3 Data analysis

The analysis of statistical data collected from the UK survey in Phase 1 of this study was conducted using SPSS19, with findings for foster care reported in Chapter 3 and for residential care reported in Chapter 4. Descriptive statistics – means, standard deviations and ranges – were calculated for the number of total allegations and substantiated cases of abuse or neglect, together with outcomes for children observed in each of the three years. Using these mean values, rough estimates were made for the whole of the UK.

In addition to comparing the mean number of allegations and variations reported by respondent local authorities in each country, and then the total annual estimate of cases, it is possible to use official figures on the total numbers of children in foster and residential care to calculate an approximate rate of allegations per 100 children (Department for Education, 2012d, Scottish Government, 2013, Welsh Assembly Government, 2012). Each of the UK's four nations differ in the way they collect and publish their statistics, and in the

date on which the figures are collected (see Munro et al., 2011)[9] There are also differences in the definition of looked after children in Scotland, due mainly to legislative and practice differences, with children living at home with parents under a Supervision Order classified as looked after, and with Scottish local authorities making greater use of this type of arrangement than other parts of the UK. ANOVA tests using post-hoc Tamhane were used to identify any significant differences between the rates observed in England, Scotland and Wales. Numbers and percentages reported for Phase 1 are generally stated to one decimal place, whereas in Phase 2 they have been rounded to the nearest whole number, due to the lower sample sizes involved.

Statistical data arising from the Phase 2 survey of substantiated allegations provides a description of patterns of abuse and its outcomes for children and carers in these settings. The sample sizes are small – 118 children in the foster care sample and 28 young people in the residential sample. For these reasons, non-parametric exact tests of association were used (including, for example, Fisher's Exact tests, Mann-Whitney U and Kruskal-Wallis exact tests as appropriate). A confidence level of 95 per cent (p-values of less than 0.05) was deemed to indicate statistical significance throughout. However, the findings from these sections (Chapters 5 and 7) should be viewed as being indicative rather than conclusive.

Questionnaires to social workers and managers who participated in the Phase 2 included two open-ended questions. These asked them to describe the nature of the reported abuse or neglect and the lessons learned from this case. The answers to each question ranged from comprehensive accounts to a single paragraph. Replies to these questions were typically more extensive in the fostering survey than in the residential care survey.

These qualitative data were coded using the software programme Atlas-ti 6.1. Some coding categories were developed *a priori*, based on issues identified in previous research on abuse or neglect, but others were developed in the course of reading the data. We then carried out a cross-sectional thematic analysis of the answers to these questions. In making sense of qualitative data, we took account of the data from the closed questions on individual children (e.g. on age, type of placement, type of abuse or neglect, placement duration,

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9 In England and Wales, the national figures are based on data from the SSDA903 return collected each spring from all local authorities (DfE, 2010, 2011 and 2012; Welsh Assembly Government, 2012) and we use the total number of children in foster care at 31 March for each year of our study (e.g. for 2011–12 we use the 31 March 2012 national statistics). In Scotland, the figures come from different time-points, both with regards to the other countries and across the three study years (31 July 2011 for our year 2011–12, 31 July 2010 for our year 2010–2011, and 31 March 2009 for our year 2009–2010) (Scottish Government, 2013).

etc.). Themes in the qualitative data from replies to the two open-ended questions were therefore analysed across cases, informed by the quantitative data available from the two surveys.

2.4 Ethical issues

The study was conducted in a manner consistent with the code of good practice for research developed by the University of York[10]. The code of practice is consistent with the Social Research Association's Ethical Guidelines 2003 and the Data Protection Act 1998.

Ethical approval for the study was obtained from the University of York's Health and Social Sciences Ethics Committee and, for England, from the Association of Directors of Children's Services (ADCS). In addition, the study was subject to further ethical scrutiny by several local authorities that participated in Phase 2 through their own internal research governance procedures.

The Social Policy Research Unit at the University of York (SPRU) has clear procedures in place to ensure the highest standards of data management and data security. All data were stored in password-protected computer files in a secure central University file-store. The University computing network is protected from viruses and data piracy by various virus checkers and firewalls. No one outside the research team had access to research data. Manual files were securely held in locked cabinets in a locked office at York and never removed from the office. Personal details of research participants, where required, were also held in password-protected computer files in a secure central University file-store.

This study was conducted anonymously (using only local authority identifier codes to link data on children to their placements). Data transfer (from local authority information systems and the online survey) was undertaken securely. SNAP provided a highly secure mechanism for transferring Phase 2 data. With respect to the transfer of Phase 1 summary data, local authorities were given the option of making returns by secure encrypted email or secure server. As the study did not require the personal details of children or caregivers to be known (names, addresses or full dates of birth) the transfer of data did not need the direct consent of participants. This was carefully explained to and accepted by the local authorities that agreed to take part.

10 The code of practice is available at: www.york.ac.uk/staff/research/governance/policies/research-code/

2.5 Summary

This exploratory study has investigated the scale, nature and consequences of allegations and confirmed cases of abuse or neglect of looked after children by adults charged with their care and upbringing. It provides evidence for both residential and foster care. The study took place over a period of 12 months (July 2012–June 2013) and involved two phases:

- Phase 1 involved a brief survey of all local authorities across the UK to provide estimates of the scale, characteristics and outcomes of allegations concerning looked after children.
- Phase 2 involved a more detailed follow-up (by online survey) of confirmed cases of abuse or neglect in foster and residential care in 24 local authorities.

Information for Phase 1 was achieved through a Freedom of Information request to all 211 local authorities in the UK. In total, 156 local authorities responded, giving a response rate of 74 per cent.

Phase 2 was achieved through an online follow-up of substantiated allegations of abuse or neglect identified in Phase 1. Although a large number of local authorities were the subject of an initial approach, just 24 were able to provide completed questionnaires within the timescale of the project. Out of 159 fostering questionnaires that were sent out, 87 completed questionnaires were returned, concerning 118 children, making a response rate of 55 per cent.

With respect to residential provision the potential pool was smaller. Phase 2 questionnaires were eventually received from eight of these 24 local authorities. Of the 60 residential questionnaires that were sent out, 24 were returned, accounting for 26 children (a response rate of 40 per cent).

The focus of the study gives rise to some limitations. It concerns allegations made against adult carers and to incidents arising within placements that were referred to LADOs (or their equivalents in other countries in the UK). As such, the study excludes incidents occurring while children were away from placement, allegations concerning placement peers and allegations that were not subject to formal investigation by LADOs. The study is also unable to draw directly upon the views of foster carers about the effects of allegations – especially those that are unproven – on their lives and on those of the children placed with them.

UK-WIDE SURVEY OF ALLEGATIONS CONCERNING THE ABUSE OR NEGLECT OF LOOKED AFTER CHILDREN

Chapter 3

Allegations in foster care: the scale and nature of the problem

As we saw in Chapter 1, evidence on the extent of abuse or neglect in foster and residential care in the UK is extremely limited and much of the evidence that does is exist is out of date, particularly in relation to residential care. The first stage of this project involved a survey of all 211 local authorities in the UK, using a Freedom of Information (FOI) request, as described in Chapter 2. This is the first survey to provide comprehensive evidence on the scale and nature of recorded abuse or neglect in foster and residential care settings. We asked the Local Authority Designated Officers responsible for managing allegations against those who work with children (known as LADOs in England), to provide us with information on the number of allegations reported, how many of these were substantiated or unsubstantiated and how many resulted in the permanent removal of children from placements. We then used these figures to estimate the rate of allegations and substantiated abuse or neglect per 100 children in foster and residential care, and to investigate how these rates vary both between local authorities and between the countries of the UK.

This chapter reports the results of our UK survey in relation to foster care and Chapter 4 presents the findings on residential care. It is important to bear in mind that our figures relate to numbers of allegations, not the numbers of children involved in those allegations. Some allegations may involve more than one child and some children may make more than one allegation in a year.

3.1 Total numbers of allegations of abuse or neglect in foster care reported by local authorities

Local authorities were asked to tell us the total number of allegations of abuse or neglect of children in foster placements referred to the designated manager responsible for safeguarding looked after children from 1 April to 31 March in three successive years (2009–2012). Table 3.1 shows the mean number of allegations per local authority and an estimate of the total number of allegations in the UK in each year (extrapolated from the data provided by the 156 authorities that responded to our survey). It also indicates the rate of allegations per 100 children in foster care across the UK each year.

Table 3.1 Number of allegations in foster care, per local authority

	2009–10 (N=137)	2010–11 (N=149)	2011–12 (N=156)
Mean number of allegations	10.12	11.08	10.85
Standard deviation	12.08	13.07	11.72
Range	0–61	0–75	0–68
UK-wide estimate (211 local authorities)	2,135	2,338	2,288
Total children in foster care (across UK)	59,005	60,978	63,914
Allegations per 100 children in foster care	3.62	3.83	3.58

On average each local authority reported between 10 and 11 allegations of abuse or neglect in each year, and this did not vary significantly over the three years. However, as this table shows, there were wide variations in the total number of allegations reported by individual local authorities. A number of local authorities reported zero allegations in each year (17 in 2009–10, seven in 2010–11, and 11 in 2011–12) and the maximum number reported varied from 61 in 2009–10 to 75 in 2010–11. Around two-thirds of local authorities had fewer than 10 allegations each year. This local variation may occur for a number of reasons. Differences may exist in the systems of recording and reporting allegations between local authorities, and in the thresholds applied when considering the level of expressed concern that constitutes an allegation of abuse or neglect. The number of children that local authorities have in foster placements at any one time may also have a bearing on the number of allegations reported, something which will be considered later in the chapter. With these caveats in mind, we estimated that the total number of allegations of abuse or neglect of children in foster placements across the UK was between 2,100 and 2,400 each year. This equates to three to four allegations per 100 children in foster care across the UK each year.

3.2 Confirmed cases of abuse or neglect in foster care

Next we considered how many of the allegations were found to be confirmed cases of abuse or neglect. While any allegation of abuse or neglect may have serious consequences and be distressing both for the foster carer(s) and the child (or children) involved, confirmed cases clearly merit the most concern. Local authorities were asked to say how many of the allegations they had reported to us had been substantiated (that is, confirmed) in each year. Table 3.2 shows the mean number of substantiated allegations per local authority per year, the standard deviation and range, together with an estimate of the total number of substantiated cases across the UK. It also shows the rate of substantiated allegations per 100 children in foster care across the UK each year.

Table 3.2 Confirmed (or substantiated) allegations in foster care, per local authority

	2009–10 (N=137)	2010–11 (N=149)	2011–12 (N=156)
Mean number of substantiated allegations	2.22	2.54	2.50
Standard deviation	3.74	3.69	3.36
Range	0–34	0–27	0–22
UK-wide estimate (211 local authorities)	468	536	528
Total children in foster care (across UK)	59,005	60,978	63,914
Substantiated allegations per 100 children in foster care	0.80	0.88	0.83

As Table 3.2 shows, on average there were fewer than three confirmed cases of abuse or neglect in foster care per local authority per year. This figure did not did not vary significantly over the three years. Again there was wide variation between local authorities in the number of confirmed cases, with 19 local authorities reporting no cases in all three years and one reporting a total of 78 confirmed cases in the three-year period. Overall, only seven local authorities reported more than five confirmed allegations in all three of the study years, and these were mainly the larger authorities in terms of the total number of looked after children.

Extrapolating to all UK authorities from these reported figures, we estimate that the total number of confirmed cases of abuse or neglect in foster care across the whole of the UK is between 450 and 550 per annum, which equates to less than one substantiated allegation per 100 children in foster care across the UK each year. However, the total number of *children* experiencing abuse or neglect is likely to be slightly higher since, as we will see in Chapter 5, some confirmed cases involve more than one child.

We also used these estimates to calculate the proportion of all allegations of abuse or neglect of children in foster care referred to LADOs (or equivalent officers) that were subsequently confirmed. In 2009–10, 21.9 per cent of cases were confirmed (304 out of 1386), in 2010–11 this rose to 23.0 per cent (379 of 1651) and in 2011–12 it was also 23.0 per cent (390 out of 1692). Across nearly three-quarters of local authorities in the UK, therefore, between one-fifth and one-quarter of all allegations were substantiated.

While previous evidence is scarce, the NFCA Agency Survey in the late 1990s came to similar conclusions, finding that 22 per cent of allegations of abuse in foster homes had been substantiated (Nixon and Verity, 1996). As is the case with the current study, the researchers stated that they had no information on the definition of abuse or neglect used in the cases reported. Studies in the USA have

reported higher substantiation rates, ranging from 30–38 per cent (California Department Of Social Services, 2001, Rosenthal et al., 1991) to around 50–55 per cent (Cavara and Ogren, 1983, Spencer and Knudsen, 1992) of all allegations of abuse or neglect. It is difficult to know whether these figures reflect higher rates of abuse or neglect in foster care in the USA or whether they are instead the product of different thresholds for responding to allegations in the states in which these studies were conducted and/or to different definitions of behaviours considered serious enough to constitute abuse.

3.3 Unsubstantiated allegations of abuse or neglect in foster care

The corollary of our findings on confirmed cases of abuse or neglect is that the remainder, over three-quarters of all allegations (77–78 per cent), were *not* substantiated.

Information on the breakdown of unsubstantiated allegations in at least one of the study years was only available from 85 local authorities (involving a total of 1,490 allegations). In this sub-sample of 85 authorities, a total of 392 allegations were confirmed (26.3 per cent, so slightly higher than the full sample) with the remaining 1,098 (73.7 per cent) not substantiated. Of the 1,098 allegations that had not been substantiated, 436 (39.7 per cent) were reported to be unfounded, 637 (58.0 per cent) were unsubstantiated due to insufficient evidence and 25 cases (2.3 per cent) were still under investigation. Thus, although only 26 per cent of all allegations were confirmed (in this sub-sample of 85 local authorities) only around 30 per cent were deemed to be unfounded. The remaining 43 per cent of allegations were unsubstantiated due to a lack of evidence, making it difficult for professionals to decide on the best course of action to ensure children's safety and wellbeing. Again there was wide variation between authorities, and further research is necessary to investigate the different thresholds applied in defining and reporting abuse or neglect in foster care.

3.4 Outcomes for children involved in allegations in foster care

It is concerning that a question mark remained in relation to 58 per cent of the unsubstantiated allegations (representing over two-fifths of all allegations in these authorities), as this has implications for both children and foster carers. Where there is insufficient evidence to establish whether or not the allegation is well founded, children may be unnecessarily removed from foster homes in which no abuse has occurred or, alternatively, may be exposed to further harm in placements in which abuse or neglect actually has

occurred. This illustrates the real dilemmas faced by professionals trying to decide on the best course of action in the face of a lack of clear evidence. Equally, foster carers who have done nothing wrong may have children removed from them, may feel that they remain under suspicion and, in some instances, may decide to leave fostering altogether.

As part of the FOI request, local authorities were asked whether children were removed from placements as a result of both substantiated and unsubstantiated allegations. This information was not reported by all local authorities due to a variety of factors. Some did not record this information, some stated that it would take too long or be too difficult or too expensive to find out, thereby exceeding the FOI cost threshold. During the course of our research it became clear that investigations were classified in terms of the alleged perpetrator, not the child (or children) concerned, so many local authorities did not have child-level information on the outcome of each allegation readily available.

However, 95 local authorities managed to provide details of outcomes for children for at least one of the study years. This allowed us to calculate the percentage of cases where children were permanently removed from a placement, and thus an estimate of the number of cases where children were permanently removed across the UK each year. In 2009–10, 62.5 per cent of cases where allegations of abuse or neglect were confirmed resulted in the permanent removal of the child (or children) from the placement; in 2010–11 this figure stood at 62.6 per cent, and in 2011–12 it had fallen slightly to 56.2 per cent.

From these figures we can estimate that, across the UK as a whole, around 300 cases of confirmed abuse or neglect in foster care resulted in the permanent removal of the child (or children).[11] In Chapter 5 we will use case-level data to explore the circumstances in which children were, or were not, removed from placement when abuse was substantiated.

11 In 2009–10 there were a total of 128 substantiated allegations (reported by 72 local authorities) of which 80 resulted in the removal of a child (or children) from the placement (62.5 per cent). In 2010–11 there were 163 substantiated allegations reported (90 local authorities) of which 102 resulted in the removal of a child (or children) from the placement (62.6 per cent). In 2011–12 there were 185 substantiated allegations reported (91 local authorities) of which 104 resulted in the removal of a child (or children) from the placement (56.2 per cent). Using the estimated total substantiated allegations across the UK, we can estimate that in 2009–10 293 cases resulted in permanent removal; in 2010–11 this was 336 cases, and in 2011–12 it was 297.

If we turn to look at outcomes for children in cases of *un*substantiated abuse or neglect, we find that children were removed from their placements in around 13–16 per cent of unsubstantiated cases. In 2009–10, 15.5 per cent of unsubstantiated allegations resulted in the permanent removal of the child (or children) from the placement; in 2010–11 this had fallen to 13.1 per cent, with a further slight reduction in 2011–12 to 12.7 per cent. Using UK-wide estimates, we can suggest that in each year of our study between 200 and 250 cases of unsubstantiated abuse or neglect resulted in the permanent removal of the child (or children) from the placement.[12] It is possible that in some or all of these cases the allegations could not be substantiated, but suspicions nevertheless remained, prompting the removal of children from placements. However, evidence from the recent report on the Independent Review Mechanism (IRM) for foster carers suggests that in some cases, defensive, risk-averse practice may result in children being precipitately removed when allegations are made, without a balanced assessment of the potential harm to the child of either keeping them in, or removing them from, a placement (Biehal, 2014, Pearlman, 2012).

From this we can see that almost two-thirds of substantiated allegations and more than one in 10 unsubstantiated allegations resulted in the permanent removal of the child (or children) from the foster placement in our study. Many questions remain, however, as the FOI was limited in respect of the type of information that was feasible to request from local authorities, and even then many struggled to provide us with the limited information that we asked for. We do not know at what stage children were removed from the placements: as soon as the allegation was made, during the course of the investigation or after proceedings had been completed. We also have no information on temporary removals, or reasons why children did not return to the placements when allegations were unsubstantiated. Our FOI request simply asked about "allegations that resulted in the permanent removal of the child from the placement": it did not distinguish between the child (or children) at the centre of the allegation, other foster children in the placement, or the foster carer's own children, all of whom may be affected by the investigations into allegations of abuse or neglect. All of these issues will be investigated further (so far as it is feasible) in Chapters 5 and 6, drawing on case-

12 In 2009–10 72 local authorities reported 70 cases out of 450 where allegations of abuse were not substantiated, which resulted in the permanent removal of the child (or children) from the placement (15.5 per cent). In 2010–11 this was 71 out of 540 cases (13.1 per cent) reported by 90 local authorities. In 2011–12 this was 74 out of 583 cases (12.7 per cent), reported by 91 local authorities. Thus, using UK estimates we can suggest that in 2009–10 a total of 259 cases of unsubstantiated abuse or neglect resulted in the permanent removal of the child (or children) from the placement; this fell to 237 in 2010–11 and to 223 in 2011–12.

level data from our follow-up survey of confirmed cases of abuse or neglect.

3.5 Variation in the numbers of allegations in foster care across the countries of the UK

So far we have considered UK-wide reports of allegations of abuse or neglect in foster care. But now we turn to look at any differences between the countries of the UK. As only one of the five Health and Social Care Trusts in Northern Ireland provided data, comparisons can only be made between England, Scotland and Wales. Again it is worth stressing that our figures relate to the number of allegations, not the number of children involved in those allegations.

Table 3.3 shows the mean number of total allegations (row 1) and substantiated allegations (row 3) of abuse or neglect for local authorities (who provided this information) in England, Scotland and Wales for each of the three years of the study.

In each of the three years, there were differences in the mean number of total allegations reported by authorities in the three countries. The mean was highest each year in England (around 12 to 13 allegations per LA each year), followed by Wales (around seven to nine allegations), and lowest in Scotland (around two allegations), and

Table 3.3 Allegations of abuse or neglect in foster care, by country

	2009–10			2010–11			2011–12		
	England (N=104)	**Scotland (N=18)**	**Wales (N=14)**	**England (N=112)**	**Scotland (N=19)**	**Wales (N=17)**	**England (N=118)**	**Scotland (N=19)**	**Wales (N=18)**
Mean number of total allegations	11.78	1.83	9.07	13.11	2.21	8.00	12.86	1.89	7.50
Standard deviation	13.05	2.12	6.86	14.34	1.72	3.97	12.56	3.07	4.78
Mean number of substantiated allegations	2.79	0.55	2.54	3.04	0.53	2.24	3.00	0.42	2.28
Standard deviation	4.23	0.80	2.33	4.09	0.83	1.99	3.63	0.67	2.54
Number of allegations per 100 children in foster care	3.78	1.10	4.03	4.16	1.22	3.70	3.91	0.98	3.48
Number of substantiated allegations per 100 children in foster care	0.82	0.20	1.05	0.94	0.23	1.03	0.88	0.14	1.06
Total children in foster care	47,175	7,487	4,035	48,550	7,869	4,320	50,275	8,978	4,430

these differences were generally statistically significant[13]. Similarly, there were statistically significant differences between the countries in the mean number of confirmed cases, for those local authorities reporting at least one allegation. Again, the mean was highest each year in England (around three confirmed allegations per LA in each year), followed by Wales (around two confirmed allegations per LA each year), and lowest in Scotland (less than one confirmed allegation per LA per year).[14] However, for each individual country, there was very little change over time in the average total number of allegations reported by local authorities and in the number of these that were confirmed.

Although these figures may reflect some real difference in the numbers of allegations across the three countries, they may also reflect differences in the thresholds applied in the different countries of what is recorded by the LADO (or equivalent officer) as an allegation of abuse or neglect. Variation in the proportion of local authorities in each country with larger (or smaller) foster care populations may also help to account for these differences as larger authorities are likely to report higher numbers of allegations. Row 5 of Table 3.3 shows the number of allegations per 100 children in foster care in the respondent local authorities for each country and year, with row 6 showing the number of confirmed allegations per 100 children in foster care. For

13 In 2009–10 one-way analysis of variance was significant (F=5.61 [2, 133], p=0.05, equal variances not assumed), and post-hoc comparisons (Tamhane) showed that Scotland had a statistically significantly lower mean number of total allegations than England (mean difference=9.95, SE=1.37, p<0.001) and Wales (mean difference=7.24, SE=1.90, p=0.05). In 2010–11 one-way ANOVA was significant (F=6.63 [2, 145], p=0.02, equal variances not assumed) and post-hoc Tamhane showed that Scotland had a statistically significantly lower mean number of total allegations than England (mean difference=10.90, SE=1.41, p<0.001) and Wales (mean difference=5.79, SE=1.04, p<0.001), and that Wales also had a statistically significantly lower mean than England (mean difference=5.11, SE=1.66, p=0.09). In 2011–12, one-way ANOVA was significant (F=8.81 [2, 152], p<0.001, equal variances not assumed), and post-hoc Tamhane showed that Scotland had a statistically significant lower mean number of total allegations than England (mean difference=10.97, SE=1.35, p<0.001) and Wales (mean difference=5.60, SE=1.33, p=0.001) and that Wales also had a statistically significantly lower mean than England (mean difference=5.36, S=1.61, p=0.004).

14 In 2009–10 one-way analysis of variance was not significant (F=2.75 [2, 133], p=0.067). In 2010–11 one-way ANOVA was significant (F=4.03 [2, 145], p=0.02, equal variances not assumed) and post-hoc Tamhane showed that Scotland had a statistically significantly lower mean number of confirmed allegations than England (mean difference=2.53, SE=0.42, p<0.001) and Wales (mean difference=5.79, SE=1.04, p<0.001), and that Wales also had a statistically significant lower mean than England (mean difference=1.81, SE=0.51, p=0.06). In 2011–12, one-way ANOVA was significant (F=5.33 [2, 152], p=0.006, equal variances not assumed) and post-hoc Tamhane showed that Scotland had a statistically significantly lower mean number of total allegations than England (mean difference=2.63, SE=0.35, p<0.001) and Wales (mean difference=2.01, SE=0.61, p=0.012).

reference, row 7 indicates the total number of children in foster care in the three countries in each year.

We can see then, that even taking into account the variations in the size of the fostering populations, there are far fewer allegations (both total and substantiated) per 100 children in foster care in Scotland than there are in England and Wales, and this is true for each of the three years of the study. There are a number of possible explanations as to why far fewer allegations of abuse have been reported to us by Scottish local authorities. It may be that different thresholds are being applied to reporting cases of suspected abuse, with more allegations being dealt with in-house and thus not officially recorded. It may be that less abuse is actually occurring within foster care settings, or conversely that abuse is taking place that is not being picked up by the Scottish authorities. It is clear that more research is necessary to understand the recording and reporting systems that operate in the different countries of the UK; the differing thresholds applied to cases of abuse, and thus the differences in numbers of allegations reported to us.

As suggested earlier, local authorities record – and therefore reported to us – the number of allegations, not the number of children involved. In practice, an allegation may involve more than one child and an individual child may make more than one allegation in a year. However, with these caveats in mind, it is possible to estimate that the *minimum* percentage of children in foster care involved in confirmed cases of abuse or neglect each year was between 0.82 and 0.94 per cent in England, 1.03 and 1.06 per cent in Wales, and between 0.14 and 0.23 per cent in Scotland. These figures are broadly similar to those reported by studies that have investigated the annual incidence of abuse or neglect in foster care in various states and counties in the USA. Abuse or neglect was confirmed for 0.66 per cent of children in Maricopa County (Bolton et al., 1981); 1.3 per cent of children in Oklahoma (Billings and Moore, 2004); 0.27–1.45 per cent in California (California Department Of Social Services, 2001); 1.7 per cent in Indiana (Spencer and Knudsen, 1992), and 2 per cent in Illinois (Poertner et al., 1999).

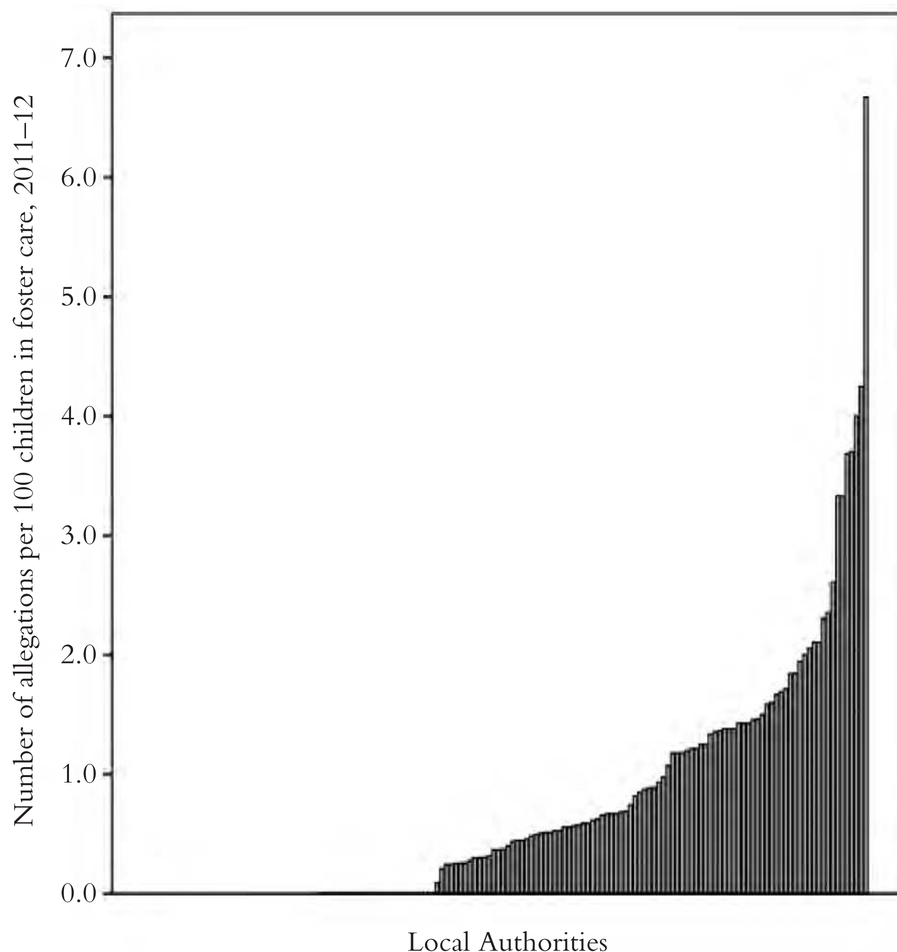
3.6 Variation in numbers of allegations in foster care between English local authorities

So far in this chapter we have considered differences across the UK as a whole and also between countries, in the mean number of allegations (both total and substantiated) of abuse or neglect, and the rate per 100 children in foster care. This section looks at any differences that can be identified between local authorities in the rates of allegations per 100 children in foster care, focusing on England. Using these figures allows us to account for variations in the size of the foster care population in different local authorities. The caveat here is

that the national statistics report the number of children in foster care for which each local authority has responsibility regardless of where they are placed, whereas allegations of abuse or neglect are recorded by the LADO (or equivalent) in the authority where the suspected abuse took place, regardless of which authority has responsibility for the children concerned.

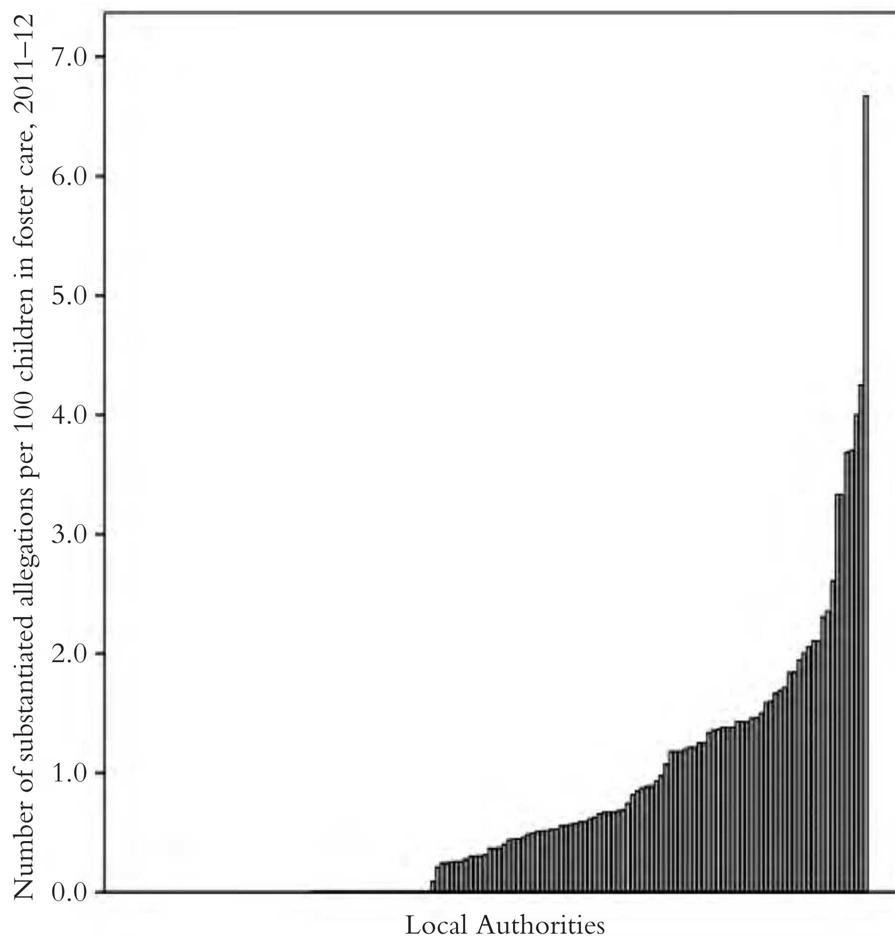
The variation is best illustrated by way of a number of graphs. Graph 3.1 shows the number of total allegations of abuse or neglect in foster care per 100 children in 2011–12 for each English local authority that responded to our FOI request (similar patterns are seen in earlier years, but the graphs are just presented for the most recent year for ease). Each bar represents one local authority, and we can see that the number of allegations per 100 reported by local authorities ranges from zero to 27.5 allegations, although only a handful of local authorities (five) reported rates higher than 10 allegations per 100 children in foster care.

Figure 3.1 Number of total allegations per 100 children in foster care, by local authority, England 2011–12



Graph 3.2 shows the total number of *substantiated* allegations per 100 children in foster care in 2011–12, for each English local authority that responded to our FOI request. Again, each bar represents one local authority, with 25 invisible bars for those with zero allegations. There is significant variation in the rates of substantiated allegations per 100 children in foster care, with a maximum of 6.67 per 100, although only eight local authorities had more than 2.5 substantiated allegations per 100 children in foster care.

Figure 3.2 Number of substantiated allegations per 100 children in foster care, by local authority, England, 2011–12



These graphs show the wide variation in rates between English local authorities. While a number have zero allegations and/or substantiated allegations, a small number do have very high rates per 100 children in foster care. Again, it cannot be assumed that children in these authorities are more vulnerable to abuse, as the differences may reflect the different foster care populations together with different recording and reporting policies and practices. These variations may also stem (in part) from different thresholds for investigation in different areas. As we will see further in subsequent chapters, there was some variation evident in the severity of the abuse experienced by fostered children involved in confirmed cases. Some of the variation found between

the countries of the UK and between local authorities may therefore be explained by differences in policy and procedure. More research is clearly needed to understand these policies and how they are applied from area to area.

3.7 Summary

- This is the first UK survey of abuse or neglect in foster care and the first in any country of the UK to present comprehensive data on the scale of the problems of allegations against foster carers, and on the number of such allegations that that are substantiated.
- Information for three successive years (1 April to 31 March 2009–2012) was requested from 211 UK local authorities via a Freedom of Information (FOI) request. Nearly three-quarters (156) of local authorities in the UK responded. Response rates were high in Wales (81.8 per cent) and England (77.6 per cent), but lower in Scotland (59.4 per cent) and Northern Ireland (20.0 per cent).
- On average, local authorities reported between 10 and 11 allegations of abuse or neglect in foster care in each of the three years, although there was significant variation between authorities. This gives a UK estimate of between 2,000 and 2,500 allegations per year, which equates to fewer than four allegations per 100 children in foster care across the UK each year.
- Just over 20 per cent of allegations were substantiated in each of the three years. On average, fewer than three allegations were substantiated per local authority, giving a UK estimate of between 450 and 500 confirmed cases of abuse or neglect in foster care per year. This represents less than one substantiated allegation per 100 children in foster care across the UK each year.
- In a sub-sample of 85 local authorities, while only 26 per cent of all allegations were confirmed, only 30 per cent were proven to be unfounded. The remaining 43 per cent of allegations were unsubstantiated due to a lack of evidence, presenting professionals with difficulties when trying to decide on the best course of action to ensure children's safety and wellbeing.
- Almost two-thirds of the substantiated cases of abuse or neglect and more than one in 10 unsubstantiated cases resulted in permanent removal of children from placements.
- There was some variation between the countries of the UK, with lower numbers of total and substantiated allegations in Scotland, compared to England and Wales. This might be due to variation in thresholds for investigation, patterns of recording and policies: more research is needed to investigate these differences.

- Local authority variation was investigated in relation to England. There was considerable variation in the mean number of allegations and confirmed cases of abuse or neglect, and in rates per 100 children for both of these.
- It is important to bear in mind that these figures refer only to abuse or neglect that is detected and investigated (that is, recorded abuse or neglect), so the true extent of the problem may be somewhat greater. As we discuss in Chapter 7, in some cases abuse or neglect in foster care may not be disclosed until a considerable time after children have left their placements. Our data indicates that at least 450–500 fostered children experience abuse or neglect across the UK each year. While foster care provides a safe environment for the vast majority of children and young people who are fostered, a minority of children, many of whom will have experienced abuse, neglect or other harm in their birth families, suffer further harm in this setting.

Chapter 4

Allegations in residential care: the scale and nature of the problem

This chapter reports the results of our UK survey of local authorities in relation to allegations of abuse in residential care. This is the first UK survey to provide evidence on the scale and nature of recorded abuse in residential care settings. Using the Freedom of Information request described in Chapter 2, we asked local authorities to provide us with information on the number of allegations made in relation to children in residential placements and undertook similar analyses to those for children in foster care, reported in the previous chapter. As with allegations in foster care, it is important to note that our figures relate to the numbers of allegations, not the numbers of children involved in those allegations. Some allegations may involve more than one child and some children may make more than one allegation in a year.

Although 156 local authorities responded to our FOI request, data on allegations of abuse in residential care settings was less forthcoming than that for foster care, for a number of reasons. Some local authorities did not systematically record allegations of abuse in residential care settings, and were unable to provide us with the information requested. Several local authorities reported that they did not have any residential provision *within* their authority, and thus did not have any allegations of abuse to report to us. Some had placed looked after children in residential settings outside of their authority, but as investigations of any allegations regarding these children is the responsibility of the *host* authority we therefore requested information on all children living in residential placements within each authority, irrespective of whether they were looked after by that authority or another one.

4.1 Total numbers of allegations of abuse in residential care reported by local authorities

Local authorities were asked how many allegations of abuse of children in residential placements had been referred to the designated manager responsible for safeguarding looked after children from 1 April to 31 March in three successive years (2009–2012). Table 4.1 shows the mean number of allegations per local authority and an estimate of the total number of allegations in the UK in each year (extrapolated from the data available provided by the 156 authorities who responded to

our survey). It also indicates the total number of children living in residential care across the UK, and a rate of total allegations per 100 children in residential care across the UK each year.

Table 4.1 Number of allegations in residential care, per local authority

	2009–10 (N=132)	2010–11 (N=140)	2011–12 (N=147)
Mean number of allegations	5.33	6.11	6.59
Standard deviation	10.26	11.94	12.31
Range	0–72	0–90	0–95
UK-wide estimate (211 local authorities)	1,124	1,290	1,391
Total children in residential care (across the UK)	11,759	11,494	11,682
Total allegations per 100 children in residential care	9.56	11.22	11.91

On average each local authority reported between five and seven allegations of abuse each year. However, as in foster care, there were wide variations in the total number of allegations reported by individual local authorities. Thirteen local authorities did not have any residential provision, and around a further fifth reported zero allegations each year. Although some authorities did report high numbers of allegations, almost three-quarters of authorities reported five or less allegations each year. As with foster care, these local variations may occur for a number of reasons. Differences may exist in the systems of recording and reporting allegations between local authorities, and in the thresholds applied when considering the level of expressed concern that constitutes an allegation of abuse. The number of children that local authorities have in residential placements at any one time may also have a bearing on the number of allegations reported, which will be considered later in the chapter. With these caveats in mind, we then estimated that the total number of allegations of abuse of children in residential placements across the UK was between 1,100 and 1,400 each year, which equates to 10 -12 allegations per 100 children in residential care each year. Although this is lower than the estimated total number of allegations in foster care observed in Chapter 3 (between 2,100 and 2,400 each year), it is actually relatively high given that the number of children in residential care is substantially smaller than the number in foster care across the UK (around 12,000 compared with 64,000 in 2011–12).

4.2 Confirmed cases of abuse in residential care

Local authorities were then asked how many of the allegations they had reported to us had been substantiated (that is, confirmed as abuse) in each year. Table 4.2 shows the mean number of substantiated allegations per local authority per year (among those who reported any allegations) and an estimate of the annual total across the UK. It also

indicates the total number of children living in residential care across the UK, and a rate of substantiated allegations per 100 children in residential care across the UK each year.

Table 4.2 Number of substantiated allegations in residential care, per local authority

	2009–10 (N=84)	2010–11 (N=97)	2011–12 (N=102)
Mean number of substantiated allegations (for those reporting any allegations)	1.88	1.85	2.07
Standard deviation	4.06	2.89	3.20
Range	0–29	0–13	0–17
UK-wide estimate (211 local authorities)	253	270	303
Total children in residential care (across the UK)	11,759	11,494	11,682
Total substantiated allegations per 100 children in residential care	2.15	2.35	2.59

As table 4.2 shows, on average there were around two confirmed cases of abuse in residential care per local authority (that reported any allegations) per year, with a very slight increase over the three years. Again, there was wide variation between local authorities, with a fairly large proportion of those who reported any allegations having no confirmed cases. For example, in 2011–12, of the 147 local authorities who provided information on allegations in residential care settings, 45 had no allegations (of which 13 reported they had no residential provision).[15] Of the 102 authorities who did report at least one allegation, 38 (over a third) had not confirmed any of the cases, and a further quarter of authorities (25) only had one confirmed case. Thus we can see that the numbers of confirmed cases of abuse in residential care are relatively low.

Extrapolating to all UK authorities from these reported figures, we can estimate that the total number of confirmed cases of abuse in residential care across the whole of the UK is between 250 and 300 per year, again showing a slight increase over the three years of the study. This represents between two and three substantiated allegations per 100 children in residential care in each year. As the discussion in Chapter 1 outlined, while official enquiries into historical abuse scandals in residential care homes have provided information on the nature of the abuse that occurred, the few UK research studies into abuse have all had small and/or unrepresentative samples. There has,

15 Authorities with no reported allegations and those with no residential provision in their area were excluded from our calculation of the mean number of substantiated allegations. Any children these authorities placed in out-of-authority homes would be the responsibility of LADOs in the host authorities. This group should therefore appear in the survey returns of the LADOs in the host authorities.

until now, been no representative survey of the incidence of abuse in residential care across the UK, so these estimates represent a significant advance in knowledge.

We also used these estimates to calculate the proportion of all allegations of abuse of children in residential care referred to LADOs (or equivalent officers) that were subsequently confirmed. In each year of the study, around one-fifth of all allegations were substantiated, a similar proportion to that found in foster care settings. In 2009–10, 22.5 per cent of cases were confirmed (158 of 703), in 2010–11 this was 20.9 per cent (179 of 856) and in 2011–12 it was 21.8 per cent (211 of 969).

4.3 Outcomes for children involved in allegations of abuse in residential care

As part of our FOI request, local authorities were asked how many allegations of substantiated and unsubstantiated abuse had resulted in the permanent removal of a child (or children) from the placement. Reporting information on outcomes of allegations seemed particularly difficult for local authorities, and there is much missing data. For example, in 2011–12, of the 102 local authorities who reported at least one allegation, almost half (48) could *not* provide information on the number of cases that had resulted in permanent removal of the child (or children) from the placement. As was the case in relation to foster care, this information was not reported by all local authorities due to time and cost implications, as the LADOs (and equivalent designated officers) who responded to our FOI request recorded information in terms of the alleged perpetrator, not the child (or children) concerned, so many did not have child-level information on the outcome of each allegation readily available.

We have tentatively used the data from the remaining authorities to calculate the percentage of cases where children were permanently removed from a placement, and thus an estimate of the number of cases where children were permanently removed across the UK each year. Overall, less than one in five substantiated cases of abuse in residential care resulted in the removal of the child from the placement each year, although the proportion was significantly lower in 2010–11.[16] From these figures we can cautiously estimate that, across the UK as a whole, fewer than 50 cases of confirmed abuse in residential care resulted in the permanent removal of the child (or children) each

16 In 2009–10, 19.2 per cent of cases where allegations of abuse or neglect were confirmed resulted in the removal of the child (or children) from the placement; in 2010–11 this figure stood at 8.8 per cent; and in 2011–12 it was 16.3 per cent.

year[17]. These findings are corroborated in the follow-up survey of cases of confirmed abuse, documented in Chapter 7, which found that it was very rare for a confirmed allegation to result in children being removed from the placement.

If we turn to look at the outcomes for children in cases of abuse that were *not* subsequently confirmed, we find that only a tiny proportion of children (between 0.4 and 2.4 per cent) were removed from their placements, although the reliability of these figures is potentially compromised by the low numbers involved, and thus national estimates cannot be made.[18]

From this we can see that less than one in five cases of substantiated allegations, and only a tiny proportion of unsubstantiated allegations of abuse in residential care resulted in the removal of the child from the placement each year, far lower than the proportions removed as a result of allegations of abuse or neglect in foster care.

4.4 Variation in the numbers of allegations of abuse in residential care across the countries of the UK

So far we have considered UK-wide reports of allegations of abuse in residential care. But now we turn to look at any differences between the countries of the UK. As only one of the five Health and Social Care Trusts in Northern Ireland provided data, comparisons can only be made between England, Scotland and Wales. Again it is worth stressing that our figures relate to the number of allegations, not the number of children involved in those allegations.

17 In 2009–10 there were a total of 52 substantiated allegations (reported by 47 local authorities) of which 10 resulted in the removal of a child (or children) from the placement (19.2 per cent). In 2010–11 there were 68 substantiated allegations reported (55 local authorities) of which six resulted in the removal of a child (or children) from the placement (8.8 per cent). In 2011–12 there were 92 substantiated allegations reported (54 local authorities) of which 15 resulted in the removal of a child (or children) from the placement (16.3 per cent). Using the estimated total substantiated allegations across the UK, we can estimate that in 2009–10 49 cases resulted in permanent removal; in 2010–11 this was 24 cases, and in 2011–12 it was 49.

18 In 2009–10 there were a total of 191 unsubstantiated allegations (reported by 47 local authorities) of which just four resulted in the removal of a child (or children) from the placement (2.1 per cent). In 2010–11 there were 206 unsubstantiated allegations reported (55 local authorities) of which just five resulted in the removal of a child (or children) from the placement (2.4 per cent). In 2011–12 there were 264 unsubstantiated allegations reported (54 local authorities) of which just one resulted in the removal of a child (or children) from the placement (0.4 per cent).

In addition to comparing the mean number of allegations and variations reported by respondent local authorities in each country, and then the total annual estimate of cases, it is possible to use official figures on the total numbers of children in residential care to calculate an approximate rate of allegations per 100 children (Department for Education, 2012d, Scottish Government, 2013, Welsh Assembly Government, 2012). To allow cross-country comparisons, figures for each country were established which, as far as possible, included the same types of looked after children (i.e. those in secure units/children's homes/hostels, residential schools and other residential settings). There are some caveats to this analysis, which were discussed in more detail in Chapter 2: each of the UK's four nations differ in the way they collect and publish their statistics, and in the date on which the figures are collected (see Munro et al., 2011); there are also differences in the definition of looked after children in Scotland, due mainly to legislative and practice differences, with children living at home with parents under a supervision order classified as looked after, and Scotland making greater use of this type of arrangement than other parts of the UK. An added point of particular salience to the residential figures is that the national statistics refer to the numbers of children in residential care for which an individual local authority has *responsibility*, regardless of where those children *reside,* whereas, as noted above, local authorities collect data on allegations relating to children *living* in their authority, irrespective of which authority has *responsibility* for the children concerned. The proportion of children placed in residential placements that are outside of the local authority that has responsibility for them is substantial. In England, for example, 46 per cent of children in residential care are placed outside the boundary of their local authority (Department for Education, 2012c). It is therefore not possible to compare rates of allegations in residential care for individual local authorities.

Table 4.3 shows the mean number of total allegations (row 1) and substantiated allegations (row 3) of abuse for local authorities (who provided this information) in England, Scotland and Wales for each of the three years of the study.

There were differences in the mean number of total allegations reported by authorities in the three countries in each of the three years. The mean was substantially higher for local authorities in England (around six to eight allegations per year) than in Scotland (less than one allegation per year) and Wales (between one and two allegations per year). Although these figures may reflect true differences between the countries, they may also be affected by the total number of local of authorities and response rates in each country,

Table 4.3 Allegations of abuse in residential care, by country

	2009–10			2010–11			2011–12		
	England (N=102)	**Scotland (N=15)**	**Wales (N=14)**	**England (N=109)**	**Scotland (N=15)**	**Wales (N=15)**	**England (N=115)**	**Scotland (N=15)**	**Wales (N=16)**
Mean number of total allegations	6.64	0.73	1.07	7.56	0.8	1.33	8.1	0.67	1.75
Standard deviation	11.33	1.49	1.38	13.17	1.32	1.54	13.53	0.9	1.95
Mean number of substantiated allegations (for those reporting at least one allegation)	2.05	1.25	0.43	2.07	1	0.22	2.32	0.67	0.56
Standard deviation	4.31	1.5	1.13	3.06	1	0.44	3.39	1.03	0.73
Number of total allegations per 100 children in residential care	11.67	1.82	9.68	14.21	2.20	13.79	15.41	1.66	18.06
Number of confirmed cases of abuse per 100 children in residential care	2.59	0.83	1.94	2.97	0.92	1.38	3.34	0.66	3.23
Total children in residential care	8,490	1,467	195	8,165	1,272	195	8,080	1,461	195

and by the difference in the proportion of local authorities reporting no allegations – in 2009–10, in England, just over a quarter (28.4 per cent) of local authorities reported no allegations, compared with nearly three-quarters (73.3 per cent) in Scotland, and half (50 per cent) in Wales.

Similarly, there were differences between the countries in the mean number of allegations that were substantiated, although the number in each country is low. Again, the mean was highest each year in England (around two confirmed allegations per local authority in each year), followed by Scotland (approximately one confirmed allegation per authority each year), and lowest in Wales (less than one – around 0.5 – confirmed allegation per authority each year).

Although these figures may reflect some real differences in the numbers of allegations across the three countries, they may also reflect differences in the thresholds applied in the different countries of what is recorded by the LADO (or equivalent officer) as an allegation of abuse. Variation in the proportion of local authorities in each country with larger (or smaller) residential care populations may also help to account for these differences, as larger authorities are likely to report higher numbers of allegations. Row 5 of Table 4.3 shows the number of allegations per 100 children in residential care in the respondent

local authorities for each country and year, with row 6 showing the number of confirmed allegations per 100 children in residential care. For reference, row 7 indicates the total number of children in residential care in the three countries in each year.

We can see then, as with foster care, that even taking into account variations in the size of the residential care populations, there are far fewer allegations (both total and substantiated) per 100 children in residential care in Scotland than there are in England and Wales, and this is true for each of the three years of the study. In England, there does appear to be a slight upward trend in the number of substantiated allegations per 100 children in residential care, but it is not possible to identify such a trend in the other countries, possibly due to the low sample sizes.

The between-country differences may reflect different practices in dealing with allegations, and different thresholds for the reporting and recording of cases of suspected abuse. There may also be differences in the make-up of the residential care populations in the three countries. It is clear that more research is necessary to understand the recording and reporting systems that operate in the different countries of the UK, the differing thresholds applied to cases of abuse, and thus the differences in numbers of allegations reported to us.

4.5 Summary

- This chapter presented the findings from the first comprehensive survey of local authorities on the incidence of allegations and confirmed cases of abuse of children in residential care. The survey covered three years, from 1 April 2009 to 31 March 2012.
- The number of children placed in residential care across the UK is far smaller than that in foster care. For example, in England there were around 50,000 children cared for in a foster placement at 31 March 2012, representing 75 per cent of all looked after children, compared with just 8,000 (12 per cent) in residential placements.
- Several local authorities do not have any residential provision in their area, and place children in out-of-authority placements were necessary.
- On average, each local authority reported that between five and seven allegations of abuse had been reported to the LADO (or equivalent officer responsible for safeguarding looked after children) each year. This gives an annual UK estimate of between 1,100 and 1,400 allegations, equating to between 10 and 12 allegations per 100 children in residential care. Although lower in absolute terms than the estimate for foster care, when the relative sizes of the foster and residential care populations are taken into account it is actually higher.

- Around a fifth of allegations in residential care were substantiated, a similar proportion to that found in foster care settings. On average, there were around two confirmed cases of abuse in residential care per local authority (that reported any allegations) per year, although there were a significant number reporting zero cases. Overall, there are an estimated 250 to 300 confirmed cases of abuse in residential care across the UK each year, equating to between two and three confirmed allegations per 100 children in residential care each year.
- One notable finding is that the proportion of children removed from residential placements as a result of allegations is far lower than in foster care, around 9 to19 per cent in confirmed cases and just 0.4 to 2.4 per cent in unsubstantiated cases.
- As with foster care, significant differences were observed between the countries of the UK, with far lower rates of allegations – both confirmed and unsubstantiated – in Scotland than in England and Wales.
- These findings point towards differences in reporting and recording strategies and thresholds both between the countries of the UK and between individual local authorities. While the number of children affected by allegations of abuse in residential care is relatively low – fewer than 3.5 confirmed cases per 100 children in England and Wales in 2011–12, and less than one (0.66) case per 100 children in residential care in Scotland – more research is needed to understand why these cases occur and what can be done to prevent abuse in the future.

EXPLORING SUBSTANTIATED CASES OF ABUSE OR NEGLECT

Chapter 5

Patterns of abuse or neglect in foster care

Chapter 3 established reliable estimates of the scale of allegations in foster care across all four countries of the UK, finding that between one-fifth and one-quarter of all allegations were substantiated as abuse or neglect. This chapter provides a more detailed focus on these substantiated allegations. It considers the nature of abuse or neglect experienced by children in foster placements. It explores the characteristics of these children and foster carers, describes the different types of foster placements in which these allegations arose and examines outcomes of these investigations for children and their carers. In doing so, we will explore (so far as we can) how these factors interact with different types of abuse or neglect. This chapter will describe patterns of abuse or neglect and its correlates. Our next chapter will utilise qualitative findings from the survey to explore the experiences of children and foster carers associated with these patterns.

Phase 2 fostering questionnaires were returned by 24 local authorities. Out of 159 questionnaires that were sent out, 87 completed questionnaires (54.7 per cent) were returned. In total, these 87 allegations concerned 118 children.[19] Three-quarters of the allegations concerned single children (77 per cent: 67 allegations), while others involved multiple children. Twelve cases concerned two children; five cases involved three children and a further three cases concerned four children.[20] It is important to sound a note of caution. This is a relatively small sample size from which to draw firm statistical conclusions. All findings should therefore be seen as exploratory and indicative.

We will begin by describing the different forms of abuse or neglect experienced by children in our sample and identifying the main perpetrators of this abuse before considering characteristics, placements and outcomes and their potential interaction with abuse or neglect.

19 Of these 87 allegations, 61 arose in English, 22 in Welsh and four in Scottish local authorities. No returns were received from Northern Ireland.

20 Findings concerning children will include the full sample (n=118); findings concerning foster carers and the specific allegations will report findings for the reduced sample (n=87).

5.1 The nature of abuse or neglect

Respondents were asked to describe the nature of these incidents; to describe what had taken place, over what period of time, and to identify the forms of abuse and/or neglect that had been involved. These qualitative findings will be presented in our next chapter. In addition, respondents were asked to categorise the abuse or neglect experienced by children in foster placements and to tick all that applied in cases involving multiple forms of abuse. These findings are shown in Table 5.1. They portray the particular types of abuse experienced by children in this sample. Of course, they cannot be said to provide a representative picture of all substantiated allegations.

Table 5.1 Types of substantiated abuse or neglect

Type of maltreatment	**Number[21] (n=108)**	**Per cent**
Physical abuse (not including restraint)	37	34
Excessive physical restraint	3	3
Sexual abuse	12	11
Emotional abuse	32	30
Neglect	18	17
Poor standards of care (falling short of abuse)	15	14
Not known	11	10

For those children where a response was provided (n=108), around one-third had experienced physical abuse, a slightly smaller proportion had suffered emotional abuse, one in nine sexual abuse and 17 per cent had been neglected. In three cases, a foster carer was considered to have exercised excessive physical restraint when attempting to control the behaviour of a young person, leading to an official complaint. In a further 15 cases, concerns centred on the quality of care provided within foster families. From the perspective of our respondents, these cases fell short of the threshold for explicit abuse or neglect, but were of sufficient concern for formal action to be taken. However we should be mindful that thresholds for classifying behaviours as abusive or neglectful, rather than as indicative of poor standards of care falling short of abuse or neglect, are likely to vary between local authorities and over time.

It is not uncommon for community samples of children referred to children's social care services for child protection or entering public care to have experienced multiple forms of abuse and other adversities within their birth families (Ward et al., 2012, Wade et al., 2011a). Given the protective function and level of scrutiny of foster placements, it is to be hoped that this would be much less

21 Although 108 responses were received (10 cases were missing), the column exceeds this total as some children had suffered more than one form of abuse. Percentages are calculated as a proportion of the108 responses (and are rounded).

likely for looked after children, although the misery that can be experienced by some children in often long-term foster placements has been highlighted in the literature (Sinclair et al., 2005a, Biehal et al., 2010). Evidence from this study does suggest that multiple forms of abuse or neglect are less common for fostered children – even though the damage caused to children may be no less severe. Taking the traditional categories of physical, sexual, emotional abuse or neglect (n=80 children), 80 per cent of these children (64) were reported to have experienced only one form of abuse or neglect.[22] Nevertheless, 13 children were reported to have experienced two, and three children three forms of abuse or neglect. Each of the latter group was reported to have experienced a combination of physical and/or emotional abuse and/or neglect at the hands of their carers – in the case of two forms, experiences were more diverse: physical and emotional abuse (eight children); emotional abuse or neglect (four children), and sexual abuse or neglect (one child). Emotional abuse was common to almost all cases of multiple abuse or neglect, a finding consistent with the wider literature (Stevenson, 2007, Howe, 2005).

5.2 Perpetrators of abuse or neglect

We also do not know enough about the perpetrators of abuse or neglect in foster care settings. This study set out to identify, in a sample of confirmed cases (n=87), who was considered to have been responsible for the allegation arising. Table 5.2 provides a breakdown of perpetrators for this sample. The table totals 88, as one case that was triggered by the actions of a single kinship foster carer's non-resident adult birth son also crystallised concerns about the quality of care and supervision provided by the foster carer. Each was therefore considered to carry a separate responsibility.

Table 5.2 Perpetrators of substantiated abuse or neglect

Perpetrator	Number (n=88)	Per cent
A foster carer fostering alone	16	18
One foster carer in a couple	38	43
Both foster carers in a couple	24	27.5
Foster carer's resident (adult) birth child	4	4.5
Another resident child	1	1
Another person	5	5.5

22 By way of comparison, among a sample of looked after children accommodated for reasons of abuse or neglect, 89 per cent had experienced two or more forms of abuse or neglect (Wade et al, 2011).

In the vast majority of cases foster carers were identified as the perpetrators of abuse or neglect. This has also been the finding of the handful of studies that have considered this issue in the UK (Nixon and Verity 1996; Hobbs et al, 1999) and the USA (Tittle et al., 2001, Zuravin et al., 1993, Spencer and Knudsen, 1992). The majority of cases concerned one foster carer, either fostering alone or in a couple, and around two-thirds of these carers were female. Where a couple were considered to be jointly responsible, all cases involved heterosexual couples. There were no clear associations between types of perpetrator and the different forms of abuse or neglect for which they were responsible. The only exception was that lone foster carers (36 per cent) or both foster carers in a couple (19 per cent) were more likely to have neglected their child(ren) than was the case for a single carer within a couple (7 per cent).[23] Neglect is generally a feature of the whole family environment.

Four cases involved a foster carer's birth child who was resident at the time the abuse or neglect took place. All involved male birth children aged 18 to 22 years at the time the allegation was made. While one case involved physical aggression towards a female foster child, the other three cases involved sexual abuse of female foster children that had generally taken place over a lengthy period of time, sometimes over several years. In two cases the allegations were historic, the young women only feeling able to disclose sometime after they had left the placement. In the remaining case, three foster children (and two adopted daughters) were removed from placement after an adopted daughter disclosed long-term sexual abuse by the birth son, about which the foster carer herself was found to have concealed evidence.

One young foster child had received a bite from the foster carer's grandchild and social work concern centred more on the failure of the foster carer to report the incident and to lie about its cause. Five other cases centred on another person linked to the placement. Two cases involved historic sexual abuse of female foster children by a foster carer's ex-partner and by a neighbour. Two others involved physical violence by a foster carer's non-resident birth son and by a neighbour's young child and the last involved lack of appropriate care by a foster carer's non-resident daughter when she had supervisory responsibility for the foster child.

Many of the foster carers in this study (43 per cent) had been the subject of earlier allegations, although not necessarily by the same child (see Table 5.3). In most instances, where evidence was provided, there was knowledge of one (n=13) or two (n=9) past allegations. However, in some cases there had been a string of low-level complaints over the period of time carers had been fostering. Past allegations by children

23 Fisher's Exact test significant at p=0.02; n=78.

were less common. Only 10 children had made a previous complaint against these carers and nine had made allegations against previous foster carers.

Table 5.3 Past allegations concerning these or other foster carers

	Yes Per cent (n)	No Per cent (n)	Not known Per cent (n)
Past allegations against these foster carers by any child (n=94)	45 (42)	55 (52)	0
Past allegations against these foster carers by this child (n=66)	15 (10)	80 (53)	5 (3)
Past allegations by this child against previous foster carers (n=63)	14 (9)	65(41)	21 (13)

5.3 Characteristics of children

UK evidence about the characteristics of foster children involved in substantiated allegations of abuse or neglect is scarce. We will therefore describe the characteristics of the 118 children included in our sample.

5.3.1 Age, sex and ethnic origin

The mean age at which these allegations were made was 9.7 years (median 9 years). As Table 5.4 shows, more than half of the children were below the age of 10 and almost one in six were reported to be below the age of five at the time this allegation was made. These latter cases were more likely to have been brought to the attention of the authorities by social workers, teachers, birth parents or other connected adults.

Table 5.4 Age of children at time of allegation

Age	Number (n=107)	Per cent (rounded)
0–4 years	17	16
5–9 years	38	36
10–13 years	19	18
14–16 years	23	22
17 years or over	10	9

More than half of the sample was female (60.5 per cent) and around two-fifths were male. Females were therefore rather overrepresented among children involved in substantiated allegations. According to Department for Education statistics on looked after children for the years 2008–2012, around 43–45 per cent of the care population was female.[24]

24 Department for Education statistics, available at: www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption.

Evidence from the limited number of studies of abuse in care in both the UK and the US suggests that girls are more likely to be sexually abused in foster care than boys (Hobbs et al., 1999, Benedict et al., 1996, Gallagher, 2000) and that boys are more likely to be physically abused by their foster carers than girls (Rosenthal et al., 1991, Cavara and Ogren, 1983). Neither proposition could be properly evidenced for this sample, in part due to sample size. However, evidence on sexual abuse was in this direction, with 10 females and two males reported to have been sexually abused.

Just over two-thirds of children in the foster sample (68 per cent) were classified as 'White', with only small numbers being drawn from other ethnic groups (see Table 5.5). Although not greatly different to the proportions of looked after children from different ethnic backgrounds nationally, compared to Department for Education statistics for years 2008–2012, rather fewer substantiated allegations concerned White children and rather more concerned children from minority ethnic backgrounds.[25] There was no clear association between ethnic origin and type of abuse, apart from a marginal finding that Black and Ethnic children were more likely to have experienced physical abuse (52 per cent) than were White children (28 per cent).[26]

Table 5.5 Ethnic origin of children in foster care

Ethnic origin	Number	Per cent
White	79	68
Black or Black British	14	12
Asian	5	4
Mixed White and Black (Caribbean or African)	4	3
Mixed White and Asian	1	1
Other ethnic group[27]	3	3
Not known	10	9
Total	116	100

25 Over the period 2008–2012 approximately 76–78 per cent of looked after children were from White ethnic backgrounds, 9 per cent were of mixed ethnic origin, 4 to 5 per cent were Asian or Asian British and 7 per cent were from Black or Black British backgrounds. Available at:. www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption.

26 Fisher's Exact test: $p=0.045$; $n=97$.

27 'Other' included three White non-British young people from Eastern Europe and the Middle East. Further analysis using ethic origin will be based on two categories: White (n=79); Black and Ethnic (n=27).

5.3.2 Disability

In the general population, there is evidence of a higher incidence of abuse or neglect among disabled children in comparison to that for non-disabled children. For example, one large community-based study in the USA found that children with impairments were 3.4 times more likely to be maltreated (Sullivan and Knutson, 2000). However, evidence concerning disabled children in contact with the child protection or looked-after systems is extremely limited (Stalker and McArthur, 2012). Evidence from three previous studies suggests that, as in the wider community, a disproportionate number of disabled children experience abuse in foster care, particularly those with learning impairments (Hobbs et al., 1999, Benedict et al., 1996, Billings and Moore, 2004).

Only small numbers of children in this study were reported to have learning, physical or sensory impairments (see Table 5.6). 'Other' included six children who were reported to be experiencing some developmental delay and one child who had a diagnosis of Asperger's Syndrome.

Table 5.6 Physical, sensory and learning impairments among study children

	Number (n=116)	**Per cent[28]**
No reported disability	84	72
Learning disability	15	13
Physical disability	5	4
Sensory disability	5	4
Other	7	6
Not known	11	9

In total, 16 children (14 per cent) had learning, physical or sensory impairments. Most of these disabled children (10) had a single impairment, while six were reported to have multiple impairments.[29] Given the numbers of disabled children, it is difficult to infer differences in relation to patterns of abuse. However, a visual inspection of the data suggested that disabled children were slightly less likely to have experienced physical, emotional or sexual abuse but were rather more likely than other children to have experienced neglect – 38 per cent were reported to have experienced neglect (six children) compared to 13 per cent of other children.[30] No other differences were evident for this sample.

28 Column does not total 100 per cent as some children had more than one disability.

29 These 16 children will be compared to those with no reported disability (n=84) in any future analyses.

30 Disability by neglect significant at: p=0.025; n=96 (Fisher's Exact test).

5.4 Care history and the foster placement

The survey allowed for new information to be collected about aspects of the care histories of these children and about the features of the foster placement they were living in at the time the allegation was made.

5.4.1 Care history of children

Table 5.7 gives the age at which these children first entered the looked after system.[31] Most children had first entered before the age of 10 and only one in eight (12 per cent) could be described as adolescent entrants, entering between the ages of 12 and 15. Most children (68 per cent, n=117), had entered for reason of abuse or neglect, a further 10 per cent for family dysfunction, and only very small numbers for other reasons. Reasons for first entry did not vary according to sex or age of children at that time.[32] Most children (65 per cent) had only experienced one episode of care. Even where children had had more than one episode (n=10), one-half had also last re-entered the system for abuse or neglect. This is important to know, since there is some evidence that where children have been abused previously they may be vulnerable to further abuse in care (Hobbs et al., 1999, Biehal and Parry, 2010).

Table 5.7 Age at first entry to care

Age	Number (n=74)	Per cent
0–1 years	20	27
2–4 years	17	23
5–9 years	22	30
10–15 years	15	20

5.4.2 About the foster placement

Table 5.8 gives a breakdown of these foster placements according to type (kinship or stranger), provider (local authority or IFA) and location (whether the child was placed inside or outside the boundary of the local authority with responsibility for their care). For reference,

31 Unfortunately for 44 children (37 per cent) the date at first entry was not provided. As a result, age at entry could not be calculated for them.

32 Reason for first entry by sex (Fisher's Exact test p=0.92, n=92) and by age at entry (Kruskal Wallis Exact test p=0.53, n=70).

these data are set against tables published by Department for Education for all children looked after at 31 March 2012.[33]

In overall terms, the patterns identified in Table 5.8 are broadly comparable and there is little evidence that substantiated allegations were more likely to have arisen in particular settings. Although a slightly higher proportion of cases had arisen in family and friends' placements and in placements provided by local authorities when compared to the proportion of children living in these settings nationally, these differences are very unlikely to be significant. The lower proportion of confirmed cases in out-of-authority placements is a consequence of the research design. With respect to these children, we were only able to include externally placed children who resided in our sample authorities. The fact that we were unable to include sample children placed elsewhere probably accounts for this lower proportion (18 per cent) when compared to the national proportion of externally placed children (36 per cent).

Table 5.8 Type, provider and location of foster placements

		Our survey (number)	**Our survey (per cent)**	**Department for Education, 2012 per cent**
Placement (n=118)	Unrelated foster care	97	82	85.5
	Family and friends care	21	18	14.5
Provider (n=91)	Local authority	63	69	55
	Independent fostering agency	28	31	30
Location (n=116)	Inside LA boundary	95	82	64
	Outside LA boundary	21	18	36

We were unable to evidence any significant associations between these placement factors and different forms of child abuse or neglect, or in relation to outcomes for foster carers.

33 Although we only report national statistics for 2012, patterns are generally quite consistent between 2008 and 2012. While overall use of foster care has slowly risen (71–75 per cent of all looked after children), the proportion in kinship care has remained stable (at 15–16 per cent). There has also been a slight decline in use of out-of-authority foster placements (35–30 per cent) over these years. Department for Education statistics for years 2008–2012 are available at: www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption.

Most children had been in their foster placement for some time, with just over one-half in placement for more than two years at the time the allegation was made (see Table 5.9). Just one-quarter had been in placement for one year or less and a similar proportion had been living there for more than five years. This distribution suggests that the likelihood of an allegation arising for this sample did not diminish greatly with time spent with particular foster carers, and that allegations may therefore occur at any point in the life of a placement. No associations were evident with different forms of abuse or neglect.

Table 5.9 Placement duration at time of allegation

Time in placement	Number (n=101)	Per cent
0–12 months	24	24
13–24 months	25	25
25–36 months	11	11
37–48 months	11	11
49–60 months	5	5
61–72 months	9	9
More than 6 years	16	16

Against a range of different placement criteria, information was also collected on (a) the characteristics of a particular placement and (b) on whether this characteristic fell within the approval range of the foster carer concerned. A wide range of placement criteria were considered, including:

- duration (whether approved for emergency, short-term, medium-term and longer-term placements)
- age (whether approved for babies and children under age 3, 3- to 4-year-olds, 5- to-11–year-olds and/or adolescents aged 12 or over)
- special needs (whether approved for children with physical or sensory impairments, learning disabilities or emotional/ behavioural difficulties).

Further analysis was undertaken to determine whether, in relation to each of these approval criteria, the placements fell within or outside the approval range of these foster carers. Table 5.10 shows the cases where there was or was not a match on duration, age and the particular needs of children. 'Not known' refers to the proportion of cases where the respondent was not sure whether the child being looked after at the time of the allegation fell within the approval range of the particular foster carer.

Table 5.10 Match between approval range of foster carers and placement characteristics

Placement characteristic	Matched Per cent (n)	Not matched Per cent (n)	Not known Per cent (n)
Duration of placement (n=85)	59 (50)	25 (21)	16 (14)
Age range of children (n=83)	51 (42)	34 (28)	16 (13)
Special needs of children (n=83)	43 (36)	31 (26)	25 (21)

Table 5.10 shows that it was not uncommon for foster carers (around one-quarter to one-third) to be caring for children who were outside of their formal approval range. However, it did seem rare for foster carers to be looking after more children at one time than they were approved for. Where this was known (n=71), only two foster carers were reported to have been caring for more children. There were no significant differences between these match variables and forms of abuse or neglect or outcomes for children and foster carers. Children were more likely to stay (rather than be removed) where the match was perceived to be good (40 per cent did so in these circumstances compared to just 21 per cent where there was no match on these criteria). However, this difference was not significant for this small sample and may be a chance finding (p=0.37; n=57).

Respondents were also asked to provide information on how long these particular foster carers had been fostering. As Table 5.11 shows, most had been fostering for a substantial period of time, over half for more than five years (56 per cent). Only a small minority (8 per cent) had fostered for less than a year. The only significant association was with the fostering provider. Those fostering for local authorities had fostered for longer in comparison to those working for IFAs.[34]

Table 5.11 Duration of fostering

Duration	Number (n=87)	Per cent
Less than 1 year	7	8
1–2 years	7	8
3–5 years	15	17
More than 5 years	49	56
Not known	9	10

5.5 Outcomes for Children

Information was collected on basic outcomes for the child(ren) directly concerned in these substantiated allegations and for other fostered children living in the placement. Given the limitations that exist on the number of questions that can be asked in a survey, the focus was placed on whether or not the children were removed from placement and, if so, at what stage of the proceedings. This analysis is undertaken

34 Mann Whitney U Exact test significant at: p=0.01; n=80.

for all 87 allegations and the findings for children are presented in Table 5.12. The table combines outcomes for allegations involving single or multiple children.[35]

Table 5.12 Outcomes for children directly involved in the allegation

Outcome	Number (n=83)[36]	Per cent
The child(ren) were removed immediately or soon after the allegation was made and did not return.	37	45
The child(ren) were removed when the investigation was completed and did not return.	6	7
The child(ren) were removed for a temporary period but returned to the placement.	1	1
The child(ren) continued to live in the placement.	20	24
Other outcome or scenario.	19	23

Over two-fifths of the children directly involved in each allegation were removed promptly once the allegation had been made and did not return to the same placements. It was rare for children to be removed at a later point or just for a temporary period. Once a decision to remove a child is made it therefore appears to be final, at least for those cases that are ultimately substantiated. The seriousness of many of these allegations probably warranted prompt intervention and investigation.

However, one-quarter of children continued to live in their respective placements. A reasonable hypothesis could be that the likelihood of staying in placement might be higher where cases involved 'poor standards of care' rather than more explicit abuse or neglect. However, there was no evidence to support this proposition (p=0.79; n=79) and the factors that determine child outcome may therefore lie elsewhere. Although a range of variables were tested against outcome (whether or not the child stayed in placement), none were found to be significantly associated for this sample of children (including different forms of abuse or neglect). Of course, the size of the sample may have a bearing on these findings and ideally it would be better to explore these issues in a larger sample. However, foster carers have frequently complained about a tendency for local authorities to take pre-emptive action in removing children before investigations are properly conducted and irrespective of the nature of the allegation itself (The Fostering Network, 2004b, Swain, 2006b, Nixon and Verity, 1996). The use of discretion and professional judgement to assess which cases warrant immediate action and which do not may therefore sometimes be lacking.

35 As we have seen previously, 20 cases involved more than one child.

36 Four respondents failed to record a response.

A further quarter of the cases were described as having 'other' outcomes. These scenarios involved allegations that had been made after the children had already left the placement (nine), a relatively common situation for older females who had been sexually abused. Alternatively, they included moves that were made because the child requested it or they refused to go back (three); moves that occurred sometime later in a planned way (four); or in response to a further allegation (two). In one instance, a child simply refused to leave the placement.

Of course, allegations may affect not only those children directly involved but also other children fostered with the family.[37] Basic information was therefore sought on outcomes for these children. Unfortunately our respondents could only provide partial information. In one-third of these households (n=28) no other fostered children were resident and in another 21 cases information was either not provided or not known. Where information was reported (n=38), just over half of the children had continued to live in the placement (55 per cent: n=21), while more than two-fifths (43 per cent: n=16) had been removed, generally at the time, or soon after the allegation was made (14). One 'other' scenario involved a risk assessment to the foster carer's own birth children that had not ultimately resulted in further action. It therefore appears to be quite common for these allegations to have disruptive effects that reach beyond those directly involved, and to do so before a final outcome to the investigation is known.

It was relatively rare for decisions to remove or not to remove children from their placements to be reinforced by a prior looked after children review. This probably reflects the immediacy with which decisions to remove were taken in many substantiated cases. Such reviews, to consider events in the context of the overall care plan for the child, were only evidenced in 16 per cent of cases. In almost two-thirds of cases (63 per cent), it was reported that formal looked after children reviews were not held. For looked after children, where there is no immediate risk of further harm, the planning and review procedures provide a context for assessing risks which may help to minimise further disruption to their lives, either by allowing them to remain – if it is safe for them to do so – or by ensuring that placement changes are properly planned.

37 Obviously there may also be serious effects for other non-looked after children in these foster families, but collection of data on these children was beyond the scope of the current study.

5.6 Outcomes for foster carers

The survey also provided an opportunity to collect information about outcomes for foster carers directly involved in allegations as perpetrators of substantiated abuse or neglect. Where allegations related to both foster carers in a couple, the outcomes were always recorded as being the same for both. Table 5.13 therefore combines outcome data for single and couple foster carers.

Table 5.13 Outcomes for foster carers responsible for substantiated abuse or neglect

Outcome	Number (n=79)[38]	Per cent
No further action	8	10
Provision of additional support and training	26	33
Referral to Independent Safeguarding Authority (ISA)[39]	8	10
De-registration/termination of approval	37	47
Subject to criminal prosecution	6	8
Not known	5	6

The vast majority of cases led to some form of further action, most commonly leading to the de-registration of single or couple foster carers and the removal of all looked after children resident with them. However, one-third received additional support, training and services in an attempt to remedy the behaviour or actions that had led to the allegation. As is evident from Table 5.13, some foster carers were subject to more than one outcome. Nine foster carers had two recorded outcomes and one had three. Four were referred to the ISA and were then de-registered; four were de-registered and subject to criminal prosecutions, and one foster carer was reported to have received all three outcomes.

There was some association between foster carer outcomes and whether or not the foster children remained living in the placement.[40] Where no further action was taken or foster carers were provided with additional support and training only, 64 per cent of children stayed with them or returned to the placement after a temporary stay away, compared to just 7 per cent where foster carers were eventually

38 Seventy-nine responses were received in total (eight cases were missing). The column exceeds this total as some foster carers had more than one outcome. Percentages are calculated as a proportion of these 79 responses (and are rounded).

39 The ISA has now been replaced by a new vetting and barring scheme: the Disclosure and Barring Service.

40 For the purposes of these analyses the categories in Table 5.13 were collapsed into a binary variable to reflect more or less serious outcomes: less serious (no further action/support and training); more serious (de-registration and/or criminal prosecution. Referral to ISA on its own was removed from this variable as, in these cases, the final outcome was not clear).

subject to de-registration and/or criminal prosecution.[41] However, as we found for children's outcomes, there was no clear association between the outcomes for foster carers and the particular forms of abuse or neglect for which they had been held responsible. Although this may again be influenced by sample size, the only obvious finding was in relation to sexual abuse. Where the outcome was known in these cases (n=6), all of these foster carers were subject to criminal prosecution and/or de-registration. It may therefore be the case that the severity and chronicity of abuse may be more closely associated with outcomes for foster carers: factors that we were unable to take account of in this study.

Only two other factors in this survey were significantly associated with foster carer outcomes. First, there was a difference by ethnic origin. Where foster carers were caring for minority ethnic children they were more likely to have had a less severe outcome than was the case when caring for White children.[42] Over four-fifths of these foster carers (85 per cent) received no further action or support and training only, compared to 39 per cent of carers caring for White children. The explanation for this finding is not obvious from the survey data available to us. No other significant differences were evident for Ethnic children, apart from a tendency for more of these children to be placed with lone foster carers (p=0.02; n=68), which in itself was not significantly related to outcome.

The second finding is more obvious. Where suspicions had been aroused by awareness of past allegations having been made against these foster carers, it was more likely that a particular allegation would result in de-registration and/or criminal prosecution.[43] Almost three-quarters of such cases ended in this way (72 per cent) compared to considerably less than one-third where no past allegations were known (28 per cent). In these cases a cumulative weight of evidence tended to lead to a decisive and final outcome.

Finally, we were also interested in understanding something about outcomes for foster carers where they had not been directly involved in abuse or neglect – where the perpetrator had been someone else linked to the placement. As we saw in Table 5.2, this situation only applied in 10 cases – and information about outcome was only supplied for seven foster carers. Of these, four decided to give up fostering altogether while three did not. Of course, five of these cases (at least) had been very serious, involving the sexual abuse of foster children by family members or neighbours, which may therefore rightly have raised vital questions about the capacity of these foster carers to protect the children in their care. However, on a wider

41 Fisher's Exact test: $p<0.001$; n=52.
42 Chi-square continuity correction: p=0.01; df=1; n=65.
43 Chi-square continuity correction: p=0.005; df=1; n=64.

canvas, it does also point to the fact that the potential fallout of allegations for foster carers, even where not personally responsible, may still be considerable and lead to some giving up fostering, even where allegations prove to be unfounded (see Wade et al., 2011b, The Fostering Network, 2004b, Biehal and Parry, 2010).

5.7 Summary

- This chapter provides findings from a follow-up survey in 24 local authorities of 87 substantiated allegations in foster care, concerning 118 children and young people. Almost one-quarter of these allegations concerned more than one child.
- Just over one-third of substantiated allegations involved physical abuse or restraint (37 per cent); 30 per cent involved emotional abuse; one in nine sexual abuse (11 per cent); 17 per cent neglect, and 15 cases were reported to involve 'poor standards of care' falling short of actual abuse. Most children had not experienced multiple forms of abuse.
- In the vast majority of cases foster carers were reported to have been the perpetrators of confirmed abuse, mostly involving single carers (either fostering alone or in a couple). Several cases of sexual abuse, often taking place over a lengthy period of time, involved the adult birth sons, ex-partners or neighbours of foster carers.
- Many of these foster carers (43 per cent) had been the subject of earlier allegations, perhaps a signal of future difficulties, whereas past allegations by children were less common. Most carers had been fostering for some considerable time (over half for more than five years).
- There was little clear evidence to suggest that substantiated allegations were more or less likely for children living in kinship or stranger foster placements or for those living in placements provided by local authorities or independent providers. Confirmed abuse or neglect could therefore arise in any of these settings.
- Most children had been in their foster placements for some considerable time before the allegations was made (only one-quarter for one year or less). Allegations may therefore occur at any point.
- Around one-quarter to one-third of foster carers were caring for children who fell outside of their formal approval range, although this appeared to make little difference to the forms of abuse children experienced, or to outcomes for children and foster carers.

- Over two-fifths of children were removed from their placements permanently soon after the allegation had been made. It was rare for children to be removed at a later point or for just a temporary period. One-quarter of children remained in placement, but the likelihood of staying did not vary by type of abuse experienced. It was fairly common for allegations concerning sexual abuse to only be made some time after the child had left the placement.
- Just over two-fifths of other fostered children in the placement had also been removed. It was therefore fairly common for allegations to have disruptive effects reaching beyond those directly involved.
- Almost half of substantiated allegations led to the de-registration of the foster carer; in a further third of cases foster carers were provided with additional support and training; in one in 10 cases no further action was taken, and six carers were subject to criminal prosecution. Although there was no association between these outcomes and the type of abuse, there was an association with whether or not children remained living with them.

Chapter 6

Exploring abuse or neglect in foster care

This chapter tells the stories behind the patterns identified in our statistical analysis of the fostering survey, reported in Chapter 5.[44] Our questionnaires to fostering social workers included two open-ended questions asking them to describe the nature of the reported abuse or neglect, and the lessons learned from this case (in a few cases these questionnaires were completed by LADOs, where relevant fostering social workers were not available). Replies to these questions provided valuable insights into the nature of abuse or neglect in foster care. This chapter draws on qualitative data from questionnaires on 86 cases of abuse or neglect in foster care to explore the following questions:[45]

- What is the nature of abuse or neglect in foster care?
- In what circumstances does it occur?
- Are there any warning signs?
- In what circumstances are children removed from their placements after abuse or neglect is identified?

All names used in this chapter are fictitious and some identifying details have been changed to ensure confidentiality.

6.1 The nature of the abuse or neglect

Some previous studies have analysed abuse or neglect in foster care in terms of the proportions of children who experience physical, emotional and sexual abuse or neglect; only a few have included descriptions of the nature of abuse or neglect in this setting (Biehal et al., 2009, Morris and Wheatley, 1994, Benedict et al., 1994, Gardner, 1998)). We introduce this chapter with a few brief case examples to illustrate the nature and severity of the different types of abuse or neglect experienced by fostered children. Further illustrations will be given in the remaining sections of the chapter.

44 In some instances there may be a slight discrepancy in the numbers given between this chapter and the previous one. This is because this chapter discusses individual *cases* of abuse or neglect (n=87), some of which involved more than one child, whereas (in large part) the previous chapter reported the total number of children involved in these cases (n=118).

45 One questionnaire failed to supply any qualitative information.

The most common form of abuse or neglect in our survey was physical abuse, which was experienced by over one-third of children, as we saw in Chapter 5. Some instances were relatively minor, apparently isolated incidents. For example, in one case a child alone in a car with a foster carer was kicking and tilting the carer's seat from behind, mocking her verbal attempts to stop him; the carer eventually reached back and hit the child. This was described by the social worker as "a spur of the moment (but inappropriate) response to managing a difficult and dangerous situation". In another, a foster carer had smacked a young child's hand when she reached for a pan on the stove. Both foster carers were given additional training in managing behaviour and the children remained in the placements. These and other similar incidents were typically the result of carers under stress smacking misbehaving children without using undue force or causing injury. More serious cases of physical abuse included one in which a child had sustained several unexplained fractures and a lack of developmental progress since the placement began; in another, a foster carer had injured a child while showering him after he had soiled himself. This child had long-standing toileting difficulties, which the foster carer found difficult to manage.

Emotional abuse was reported for just under one-third of the children and had often persisted for long periods of time. In the cases for which details were provided the emotional abuse was invariably serious. Sometimes the true extent of the emotional abuse was not discovered until after children had left the placement, but in a few cases social workers were alerted to the abuse while the children were still in placement. In one case, for example, foster carers who had fostered a child for three years found her more difficult to care for once she reached puberty and refused to keep her any longer. On moving to her new placement she described how her belongings were thrown into the fire if she refused to pick them up, how she had received harsh punishments for minor misdemeanours and how she had been refused a birthday party on the grounds that she was too old. Her brother had remained with the carers, but when she saw them during contact visits with him they refused to speak to her or even look at her. Emotional abuse occurred in all types of placements, but a number of examples concerned children in long-term placements and kinship placements. These are discussed below.

There were also 12 cases in which emotional abuse was reported in combination with physical abuse or neglect. One child who made a planned move to long-term foster carers disclosed, within a few days, that her previous foster carer shouted at her in her face, had forced her to eat the evening meal she had refused for breakfast the next day, gave preferential treatment to another foster child and had smacked another young foster child. In another case the foster carer swore at the child, threw water over him, grabbed his arm making 'scram

marks' on it, made him sit on the floor and told the other children not to look at him. After being moved from the foster home, the child also disclosed that the male carer drank heavily every night and that he and the other children stayed out of his way to avoid being shouted at.

As we saw in the last chapter, neglect was reported for 17 per cent of the children in our fostering survey.[46] This pattern differs from that for children in the wider community, for whom neglect is by far the most common form of recorded abuse or neglect, followed by emotional and then physical abuse (Department for Education, 2012b). Neglect was the sole form of reported abuse or neglect for only two children in our sample. For example, one child's school had alerted social workers to the fact that the child's hygiene was poor, that she came to school in ill-fitting and dirty clothes and had an untreated skin condition. In most other cases neglect was reported in conjunction with emotional and/or physical abuse. For example, one social worker reported that a foster carer appeared to have resorted to inappropriate physical chastisement (with a slipper) and neglected (the children) physically and emotionally.

Sexual abuse was the least common form of abuse reported, reflecting the pattern for children in the wider community. Most of the 10 cases of sexual abuse (which involved 12 children) were extremely serious, but seven of them only came to light a considerable time after the children left the placements. These cases are discussed below in section 6.3, about when the abuse or neglect came to light. In one of the other three cases a girl disclosed to her respite carers that her regular foster carer had touched her inappropriately and attempted to have sex with her while, in another case, the foster carer admitted that she had fallen in love with a boy she had been fostering for several months. In the third case a social worker enquired about an argument she observed between a fostered child, Ruth, and a member of the foster family during a routine visit to the foster home. By way of explanation another fostered child, Sheila, mentioned that Ruth was in a relationship with the male foster carer. Both Ruth and Sheila were immediately removed and it subsequently emerged that both had been sexually abused by this carer.

46 Types of abuse or neglect were reported for 108 of the 118 children in the fostering survey.

6.2 In what circumstances does abuse or neglect occur?

Our survey of confirmed cases of abuse or neglect in foster care, reported in the previous chapter, showed that abuse or neglect may occur in a wide range of circumstances. It may be experienced by children of all ages, in both long-term and short-term placements and in placements with both kinship carers and unrelated foster carers. Below, we discuss our evidence on abuse or neglect in long-term foster placements and kinship placements, many of which are also long-term. When concerns arise in these placements it may be particularly difficult for social workers to decide on the best course of action as they may be more reluctant to disrupt a long-term foster placement or kinship placement when things are not going well.

6.2.1 Children in kinship placements

Recent research evidence on family and friends care is encouraging, although by no means unproblematic (Sinclair, 2005, Hunt et al., 2008, Farmer and Moyers, 2008, Broad, 2007, Selwyn et al., 2013). Outcomes for children placed in these settings appear to be broadly similar to those for children in other foster settings, but are often achieved in more adverse circumstances. Kinship carers are often more economically disadvantaged and often less well educated than other foster carers. They also tend to receive less training, may have fewer parenting skills and lower levels of social work support. In this context, outcomes appear quite impressive and familial commitment and loyalty may help to overcome these disadvantages. Placements with family members typically last longer than placements with unrelated foster carers, partly because relatives may show a higher level of commitment to the children, but also because social workers may be more reluctant to disrupt a kinship placement (Farmer and Moyers, 2008).

Substantiated allegations against kinship carers in this study included a range of concerns, some extremely serious and some less so. Some cases concerned apparently isolated incidents in which kinship carers hit children in an inappropriate response to their challenging behaviour, sometimes sufficiently hard to cause bruising. In one example a child's grandmother had slapped him across the face and openly admitted that she had lost patience when struggling to manage his behaviour. In other cases children experienced multiple incidents of physical punishment. It was reported that Paul's uncle, for example, "could not tolerate" his challenging behaviour without resorting to physical chastisement. The placement was closely monitored but the true extent of the abuse was not revealed until after Paul was moved, when he disclosed further episodes of physical punishment.

There were also reports of emotional and sexual abuse or neglect in kinship foster placements. Adrian, for example, told his respite carer that one of his grandparents had hit him and, although this was not substantiated, the allegation was viewed as an indication of his unhappiness in the placement. His grandmother had said that she did not like Adrian and felt no bond with him. Attempts were made to support the placement through intensive input from a therapeutic social work team, but there were continuing concerns about her lack of emotional warmth and he was moved. The social worker commented that "although they are grandparents, we cannot assume that love for the child will automatically exist." In another case there was a report of sexual abuse, when a child disclosed that her uncle had kissed her and that this had marked the start of a relationship between them.

A further case concerned questionable standards of care by Andy's aunt, involving her own alcohol abuse, the alleged drug-dealing of another member of the foster family, and his assault on another relative living in the foster home. In this case and at least one other, minimal supervision of the placement over a number of years meant that poor standards of care – or actual abuse – were allowed to persist. However, other kinship carers were reported to have received a high level of support, even if in many cases this had not succeeded in improving the care provided.

As the above examples show, the types of abuse or neglect experienced by the children placed with relatives did not differ in nature to those experienced by children fostered by unrelated carers. Despite the potential benefits of kinship care, some children may experience abuse or neglect, as previous studies have also found. For example, a study by Hunt et al (2008) of children fostered by family or friends reported child protection concerns (mainly neglect) in relation to 10 per cent of the placements – in some cases because kinship carers had left children with other relatives who were known to be abusive. Farmer and Moyers (2008) compared placements with kinship and unrelated foster carers and found that very poor standards of care, including physical and emotional abuse or neglect, were reported for 4 per cent of kinship and 4 per cent of unrelated fostering households (Hunt et al., 2008, Farmer and Moyers, 2008, Sinclair et al., 2007).

6.2.2 Long-term foster placements

As we saw in Chapter 5, many of the children who experienced abuse or neglect were in long-term foster placements. Some have suggested that these children may be at greater risk of abuse or neglect, as the level of day-to-day professional intervention in their lives is likely to be lower (Morris and Wheatley, 1994). Professionals therefore need to be alert to the possibility of abuse or neglect in apparently stable long-term placements.

Abuse or neglect in long-term foster placements may range from a single incident occurring in an otherwise successful placement to persistently abusive or neglectful behaviour over a lengthy period of time. For three children in long-term foster placements, the abuse only came to light after they had left their placements. In two of these cases the sexual abuse of a fostered child was only discovered when the abuse of other children in the foster family prompted further investigations. In the third case, Richard only disclosed that he had been regularly slapped by a foster carer after he had moved to a new placement. He had been seen regularly by social workers but had not disclosed the physical and emotional abuse that subsequently came to light. Recognition of the abuse may have been hindered by the fact that he had been told not to tell anyone about the abuse – he was very vocal about his wish to remain with this family, and his foster carers gave the appearance of being highly committed to him, although it later emerged that they had pressurised him into colluding in covering up their abusive behaviour. However, despite professing their commitment to the child, they had been openly rude and uncooperative to work with, and there was some suggestion that professionals had not challenged them sufficiently.

One case was particularly shocking due to the failure of professionals to react to a series of warning signs regarding two brothers, Alex and Daniel, over a five-year period. These included concerns raised by their school; by an anonymous caller; by one of the boy's friends, and by the boys themselves. These began when the brothers expressed their unhappiness in the placement and said that their foster carer shouted at them. Their school later raised concerns that the boys appeared stressed and reluctant to go home to their foster carers after school. Over the years the boys told social workers on a number of occasions that they were unhappy in the foster home, that the foster carer was always shouting at them, that she was unkind and that she had slapped one of them in the face. Four years after the initial allegation, a strategy meeting concluded that they were being emotionally abused but that this did not reach the threshold for significant harm, and the carer was provided with training and support. However, a few months later another social worker felt that the boys appeared guarded and anxious and a different foster carer raised concerns about the care they were receiving. After a further strategy meeting they were moved to a new placement where they settled down and appeared much happier. This case was notable for the marked failure to listen to children and to take the concerns of others seriously. These children had had several changes of social worker, which may have compounded the failure to listen to them and to intervene much earlier to improve and monitor the parenting they received or, alternatively, to remove them from the placement at an earlier stage. However, staff turnover alone cannot explain the lack of coherent oversight of this case.

6.3 When did the abuse or neglect come to light?

In most cases, allegations of abuse or neglect were made by or about children at around the time the abuse or neglect occurred. In several cases children disclosed the abuse to respite carers or teachers. However, in some cases children made allegations several months later and, worryingly, in many cases the abuse or neglect only came to light after the children had left the placement in question.

Half of the historic allegations of abuse or neglect concerned sexual abuse. This was the least common form of abuse or neglect reported in this survey, but in seven of the 10 reported cases of sexual abuse, the abuse was not disclosed until a considerable time after the child had left the placement. In all but one case (in which a male foster carer kissed a girl on the lips on a single occasion) it was extremely serious.

In four cases of sexual abuse the perpetrator was the foster carer's son, a pattern also reported by a small sample of fostered children who called the Childline helpline (Morris and Wheatley, 1994, Utting, 1997). In all four cases, the sexual abuse had continued for several years and had only come to light sometime after the child left the placement. Julia alleged a year after she left the placement that the foster carer's son had made sexual advances towards her. She said that she had felt unable to raise her concerns at the time as her foster carers did not support her. In another case, Maggie alleged that she had been advised by her foster carer to have an abortion and that the carer's son had fathered the child. Layla disclosed a considerable time after leaving the placement that the foster carer's son had sexually abused her since she was 11 years old, and that this had continued until she left the placement at the age of 15. In all three cases the foster carers had colluded in covering up the abuse to protect their own sons.

Other cases of historic sexual abuse were equally serious. In one case a girl alleged that her foster carer's former partner had formed an exploitative relationship with her, plying her with drugs and sexually abusing her during and after her time in the placement. In another case the male foster carer was described as "a predatory paedophile" who had sexually abused his foster daughter Marian, female relatives and others over many years. In this case and some others, the long-term sexual abuse of a fostered child only came to light after investigations into the abuse of others in the household, such as the birth children, adopted children or other relatives of the foster carers.

All but one of the remaining seven cases of historic abuse involved physical abuse (being smacked or hit), often in combination with emotional abuse. In these cases, the abuse was usually disclosed shortly after children moved to their new placements. Paul, mentioned above, initially told his teacher that he had been hit by his uncle. However, Paul and his brother only disclosed the full extent of the harm they

had experienced after they moved to a new placement. Similarly, Chloe was moved after being smacked by her foster carer, but only disclosed that she had been kept shut in her room for substantial lengths of time after she had moved.

These failures to detect the abuse – or the full extent of it – experienced by some fostered children point to failures in the supervision and review of placements, but also to the real difficulty of detecting abuse or neglect if children feel unable to disclose it at the time it is happening. Our findings suggest that it may be particularly difficult to uncover sexual abuse at the time it is taking place, and that it may continue undetected for many years.

6.4 Concerns about standards of care

In a number of cases social workers completing our fostering survey indicated that the case concerned 'poor standards of care falling short of abuse or neglect'. Fostering services in England are expected to ensure a clear distinction between investigations into allegations of harm and discussions over standards of care (Department for Education, 2011c). Given the sometimes blurred boundaries between behaviours that reach a threshold for being defined as abusive or neglectful rather than as evidence of poor quality care, it is useful to consider whether the responses to our survey reflected a clear distinction between the two.

In eight of the 15 cases in which poor standards of care were reported, concerns centred on excessive alcohol use by foster carers. Several social workers mentioned concern that this could compromise the children's safety and cause them distress. Sometimes alcohol misuse was found to have persisted for a long time, raising questions about the effectiveness of the supervision and review of foster carers. In two cases, alcohol misuse was accompanied by evidence of domestic violence, and in both of these cases the carers were deregistered. Another two carers had been involved in "altercations" while drunk, in one case with an "unsuitable boyfriend". One respondent noted that it was unclear what level of use should lead to a decision that a carer is no longer fit to foster, and that her local authority did not have a clear policy on alcohol use by foster carers.

In three other cases, foster carers were found either to have downloaded pornography or 'looked after' a computer containing child pornography images for a friend. These cases raised anxieties about the carers' understanding of child protection. One of these carers had his approval terminated.

Several of the remaining cases concerned behaviours that were viewed as one-off errors of judgement by foster carers. Sometimes this involved a failure to provide effective supervision, apparently on a single occasion – for example, when two children were found playing on the roof of a building some distance from the foster home, and when a child was not appropriately supervised in a swimming pool while on holiday and nearly drowned. In the latter case concern was compounded by the fact that the foster carer did not report this incident. In two other cases it was felt that foster carers had made one-off errors of judgement in failing to seek medical advice. One had left a hospital before being seen, after a long wait with a baby she was fostering; another failed to seek medical attention for a child after being recommended to do so by his school.

Other cases concerned inappropriate attempts to deal with children's behaviour. One incident had occurred in what was reported to be "a warm, nurturing and stable placement." The foster carer was thought to have used "inappropriate physical intervention" after the child alleged that he had put his arms on her shoulders and pinned her to a chair and had pinched her nose (both of these versions of events were disputed by the foster carer). In another case, a foster carer had put her finger on a child's forehead and told her to listen in response to the child being angry and threatening after contact with her birth parents the previous day. The main concern appeared to centre on the carer's lack of insight into how the child was feeling at that point. As her supervising social worker commented, "the carer should have been more insightful on how the child was feeling and taken a different approach when the child was not listening."

In several of the above cases, professional concern was partly prompted by the foster carers' failure to follow procedures for the reporting of incidents. This could have serious consequences, including the removal of the child concerned. The foster carers (mentioned in Chapter 5) who had lied about an incident in which a fostered child, Henry, was bitten by their young grandchild and persisted in their attempts to cover up this incident for several days, were subsequently de-registered "for failure to follow policy and procedure rather than the actual incident." In the case of the carer who left a hospital before being seen after a long wait, the police were called to retrieve the baby from her and return it to the hospital for examination. The social worker commented: "If she had just ensured that hospital staff were aware that she was leaving, the incident could have been avoided." However, the social worker did not mention the effect that a stranger removing a baby from its carer to take it back to the hospital might have had on the infant concerned. In another case, a foster carer had tried, unsuccessfully, to contact a child's social worker to report that the child had an unexplained bruise on her leg, but had failed to leave

a specific message and concerns were raised when the bruise was noted by a relative during contact the next day.

Around half of the reported problems with standards of care concerned excessive alcohol use. A few concerned the downloading of pornography and most of the others involved concerns about one-off errors of judgement, inappropriate responses to difficult situations, or a failure to follow procedures. A background of previous concerns was not mentioned in relation to any of these cases. However, in some cases of errors of judgement the responses of professionals may have had serious consequences for children who were removed from their foster carers, as well as for the foster carers themselves.

6.5 Are there any warning signs?

The variety and complexity of the circumstances of these cases make it difficult to identify clear risk factors on the basis of the data available to us. Nevertheless, our data suggest that there may have been some warning signs. In some cases there had been previous concerns or allegations; in others, foster carers were thought to have been pushed to their limits or were under stress; some children had said they wished to move, and some foster carers had appeared hostile and difficult to work with. However, it is important to note that these factors may also be present in cases where no abuse or neglect has occurred. They should be viewed simply as issues that should alert professionals to possible problems with the quality of care, and in a smaller number of cases, the possibility of abuse or neglect.

6.5.1 Previous concerns or allegations

As we saw in Chapter 5, in 45 per cent of cases the foster carers in our fostering survey had been the subject of previous allegations. In some cases, the concerns expressed by children, professionals, schools or neighbours may fall short of specific allegations but may nevertheless be indicators that all is not well in the placement.

Concerns may be repeatedly raised by or about the same children in respect of the same foster carers over a number of years. In other cases previous allegations, or simply concerns, may be expressed in relation to different children fostered over a period of time. In a number of cases there had been a series of previous concerns. For example, in the case of the male foster carer described as "a predatory paedophile", there had long been lower-level concerns about the placement, including concern about the lack of warmth displayed by the female foster carer and the isolated location of the foster home. In another case, where a child was physically abused by the male foster carer while his wife was away, there had been ongoing minor concerns about the foster family. In a third case, where a foster carer employed

by an IFA had taken a child outside in mid-winter and stripped and washed him after he soiled himself, there had similarly been a number of previous allegations.

It is important to note that the high proportion of carers with previous allegations against them in this study does not mean that foster carers with a previous allegation are necessarily guilty of abuse. Our UK survey, presented in Chapter 3, found that almost a third (29 per cent: n=436) of all allegations against foster carers were deemed to be unfounded. Nevertheless, a pattern of previous allegations, or simply concerns, about a foster carer should undoubtedly be viewed as a warning sign that should be taken seriously. In the 1990s, Utting's review of safeguards for children living away from home noted that enquiries into abuse in foster care often uncover a background of previous allegations that had not been taken seriously (Utting, 1997).

6.5.2 Carer stress

In a few cases social workers, reflecting on a case, considered that the foster carers had been overstretched or stressed in other ways. There were some examples of carers being approved to foster more children than they previously had – sometimes at their own request – and then struggling to cope. The foster carer of Chloe, who had been smacked and kept in her room for long periods, was approved to foster a wide age range of children but was used to fostering teenagers rather than young children like Chloe. She later admitted that she felt ill-equipped to meet the needs of such a young child, even with support. Similarly Louise (who had been head-butted by her foster carer) was a teenager who had been placed, in an emergency, with foster carers looking after two younger children. The foster carers had insisted that they could manage but, according to the social worker, struggled to cope with the competing demands of the three children and the incident occurred soon after the placement was made. These cases, in which social workers thought that the foster carers had been overstretched, often (though not always) involved physical abuse of a relatively less serious kind.

In a number of cases, social workers suggested that the child's challenging behaviour had increased carer stress and that this stress had contributed to the abuse. They wrote of foster carers being pushed to the limit by children's behaviour. In other cases the stress contributing to the abuse was reported to be the result of events in the foster carer's own life, such as family problems or marital breakdown. For example Emily's foster carer, who had hit her and locked her in her room, was reported to be "undergoing a marital breakup and was very vulnerable herself at the time."

Clearly most foster carers under stress do not abuse the children they care for. This should be viewed as a broad indicator that the placement may not be going well and that careful supervision, support and review may be needed (with abuse or neglect a possibility in the worst case scenario).

6.5.3 The child wants to move

Listening to children is clearly important. Some children who experienced long-term emotional or physical abuse told social workers or teachers, sometimes on more than one occasion, that they were unhappy in the placement and wanted to move. This was the case for Alex and Daniel, who had experienced emotional abuse in a long-term placement for several years. Similarly Sophie, whose foster carer had pulled her off her bed by her hair, was adamant that she did not wish to remain in the placement. In this context it is worth noting that a previous study has found that younger children (typically under the age of 11), may often remain in placements in which they are unhappy without actively signalling their distress (Sinclair et al, 2007).

However, for some older children and teenagers, a wish to move may not necessarily be an indicator of harm and may instead be motivated by a resistance to attempts to set boundaries to their behaviour. In two cases, teenagers who were kicking against the boundaries that foster carers were attempting to set accused their carers of making unreasonable demands on them. Both were felt to be putting themselves at risk in a variety of ways and both occasionally went missing overnight to spend time with friends, a pattern observed in previous research (Wade et al, 1998). In both cases social workers felt the placements were meeting the young person's needs.

6.6 Foster carers who appear difficult to work with

The report on the Wakefield Inquiry into the sexual abuse of a succession of foster children by two foster carers noted that an element of these cases was the professionals' failure to challenge foster carers who were 'difficult' and aggressive (Parrott et al., 2007). In a few cases social workers in this study mentioned that foster carers had been reluctant to address concerns raised with them, and some had been hostile. The social worker of Maggie, who had an abortion after allegedly being sexually abused by her foster carer's son, noted that "the carers were not being open and working with the Department." Another social worker commented – in relation to the foster carer who had hit a child with a slipper and emotionally abused and neglected the children in her care:

> She was hostile to the local authority and difficult to work with. These issues should perhaps have been understood as common precursors to physical abuse.

The foster carers of Richard, whose experience of physical and emotional abuse in a long-term foster placement was also described earlier, the situation was more complex. His foster carers were often uncooperative and rude to professionals but at times gave the appearance of working with them, while making efforts to cover up the abuse. The social worker's account suggests that professionals had failed to challenge them but also indicates the difficulty of detecting abuse and making the right decisions about how best to intervene:

> The foster carers demonstrated a high commitment to Richard and embraced him into their family. Richard was very vocal about his wish to remain with them. Efforts were made to listen to his wishes and to try and improve his family life. The foster carers gave an appearance of working with the Department, but over time it became apparent this was a charade. It would seem they made every attempt to cover up emotionally abusive care-giving and encouraged Richard to collude in this. Lessons learned: need to challenge foster carers who are openly rude and uncooperative. It was clearly a case where a number of people struggled for a long time as to what was best for Richard, who had been in one placement for a long time: removal or continue to work to improve existing placement.

Several social workers mentioned that they sometimes found it difficult to provide effective support to kinship carers. One kinship foster carer who had herself been in care and had previously been a drug user was said to be guarded and distrustful with professionals. She would not accept that a relative living in the foster home was dealing in drugs and that his violence to another member of the household was harmful to the child. In another case a social worker felt that kinship carers who had physically and emotionally abused the children placed with them "were not willing to engage with the professionals to address the concerns regarding the child, and any suggestion was seen as criticism of their parenting." Another commented:

> Most of the relative carers I work with do not like social services and they are very guarded. In this situation the child was very difficult and the older she became the more difficult she became. Support was inputted but the carers were reluctant to engage in the support.

In these circumstances, social workers reported that they found it difficult to engage carers in working openly and honestly with them. However, as we have seen, similar comments were also made regarding some unrelated carers who had abused children in their care.

6.6.1 Institutional factors

There was evidence that in some cases institutional factors contributed to delays in detecting or responding to abuse or neglect. In the case of Alex and Daniel, for example, the worker noted that the turnover of social workers had contributed to the failure to see a pattern in the concerns expressed by the boys, their school and others over the years, although there had also clearly been failings in the review of the case by senior staff. This was not the only case in which staff turnover was an issue.

There was also a failure, in this case and some others, to coordinate information from different sources. In one case, involving physical abuse and neglect, the social worker noted how staffing problems and failures in information sharing and inter-agency working meant that warning signs were missed. A failure to agree on what counted as sufficiently harmful behaviour to warrant intervention was also noted. She listed what she saw as the lessons learned from this case which, in many respects, echoes the lessons learned from cases of abuse by children's birth families:

> (1) Large turnover of staff and not keeping up to speed on all information. (2) Different views and opinions and standards of care and home conditions between workers. (3) Over-familiarity with carers from workers. (4) Different standards between childcare workers. (5) Information not shared by GP and school (personal hygiene, lateness, poor attendance). (6) Foster carers struggling to manage despite not being open and honest about difficulties. (7) Not taking information and advice on board. (8) Not attending training. (9) Not keeping records. (10) Cancelling appointments.

Poor coordination was also mentioned in another case, along with the need for timely provision of resources to support placements. An incident of physical abuse occurred after a period of several months in which a young person's physically aggressive and self-harming behaviour had been escalating. The reasons were reported to be complex, including the carer's unresolved personal issues and loss of informal support, but the social worker also pointed to institutional factors that appeared to have compounded the child and carer's difficulties:

> The lessons learnt from the case are that there are a lack of resources and coordinated service provision when needed. For example, whilst multi-disciplinary meetings were held (health, education and social services) psychological input and specialised respite provision weren't available at the critical times needed.

The need to share information was also highlighted in relation to children placed outside the boundary of the local authority responsible for them. In these circumstances the LADO (or other designated officer) in the host authority is responsible for the investigation. In one case, in which a child had been removed from an independent foster placement, the LADO reported that information had clearly not been shared widely enough to protect other children:

> This local authority had stopped using these carers. However children were placed from other local authorities. Information appears to have been kept from the fostering agency by the carer.

Problems with the supervision and review of foster placements were mentioned in many cases. In some cases alcohol abuse by foster carers, or the sexual or emotional abuse of children, had persisted for years without being detected. Several social workers highlighted the need for greater awareness of the vulnerabilities of all members of the household, including awareness of when foster carers are under particular stress. Stresses may increase as a result of escalating behaviour problems in the child, or due to family problems such as serious illness of a member of the household, or marital problems.

In some cases additional support or training were provided to placements under pressure but these were unsuccessful. However, there was some evidence that their effectiveness was not always reviewed. In the case of Adrian, placed with his grandmother who openly admitted that she did not like him, a therapeutic social work team had visited weekly for several months with little effect. The social worker who had taken over the case felt that a better assessment might have identified problems with the grandmother's capacity to provide emotional warmth to this child. A review of the impact of the therapeutic team's intervention may also have led to more decisive action. In another case the social worker noted that a proper review of the impact of additional support and training on the quality of care may have revealed the continuing problems in the placement sooner and led to the earlier removal of the children.

Failures in the supervision and review of placements were mentioned in relation to all types of placement, including several long-term placements and kinship care placements. Some social workers noted that there had been little monitoring of kinship care placements and one recommended that authorities should have specialist kinship care teams to ensure adequate supervision and support for placements with connected persons.

6.7 When were children removed from placements?

Many of the children were moved from their placements as a result of the abuse or neglect they had experienced. The children still in their foster placements when sexual abuse was disclosed were immediately removed. Physically abused children who had sustained a visible injury also tended to be removed promptly, as were two children who had been roughly handled by their foster carers, one of whom was an adolescent.

However, in some cases where children had experienced physical abuse they remained in their placements. Some children who sustained no obvious injury in a one-off incident (for example after a smack) remained in the placement. Two cases in which foster carers lashed out at children during an altercation between them had different outcomes. In the first, Emily alleged that she had been in hit in the face by her foster carer, who in turn claimed that she had lost control after being hit, punched, bitten and kicked by Emily. According to the social worker: "It was a question of the carer being pushed so far that she responded by having a fight with the young person, who was very challenging." This foster carer was provided with support and training and Emily stayed in the placement. In the second case, Louise's foster carer had responded more violently to her challenging behaviour, head-butting her after she threw a phone at his head during an argument. The fact that this was a serious physical assault and that the young person had only recently been placed in this foster home may have contributed to the decision to remove her from the placement. Another foster carer had grabbed and pushed a young person during a heated argument, leaving marks on her arm. The social worker explained that the girl was allowed to remain in the placement because this was a one-off incident in an otherwise stable and positive placement, and that the carer had been struggling to cope with the girl's challenging behaviour, which had become more difficult once she reached adolescence.

Children were usually removed in cases where foster carers attempted to cover up injuries, even if these were apparently isolated incidents. In the case of Sophie, who was pulled off her bed by her hair, several factors may have contributed to the decision to remove her. Although this was an isolated incident, it was a serious assault; the foster carer's account was not consistent with the injury to the child and Sophie insisted that she would not return to the foster home. In another case, where an injury was not consistent with the explanation given by the foster carer, there had been previous low-level concerns regarding the over-chastisement and neglect of other children.

There were, however, other cases in which children were removed for less serious reasons, following isolated errors of judgement by foster carers. One case concerned the foster carers who had initially tried to cover up the fact that a foster child, Henry, had been bitten by their infant grandchild. Although professionals were not unduly concerned about the incident once the foster carers admitted it, they removed the child and de-registered the foster carers for failing to report the incident and initially attempting to cover up what had happened. Similarly, in the case of the foster carer who failed to seek medical advice when this was recommended by the school, the child was removed because she had failed to follow policy and procedure. The social worker commented that she "paid a high price as the child removed was a much-loved and integral part of the family." It seems likely that, in both cases, the children concerned paid a high price too, in being moved from placements when there were no apparent concerns that they were at risk of harm from their foster carers.

Decisions about whether or not to remove children who are apparently settled in long-term placements may be particularly difficult to make, as the consequences for the children may be damaging whatever the decision. The abuse of Philip and his brother only came to light when, after a week's respite in their foster family, another child mentioned that he had not seen Philip because, he was told, Philip he had been 'bad.' When their social worker questioned the brothers she became concerned about the forms of chastisement being used, for example being locked in their bedroom or locked out of the house. The children were removed from the placement as a result. This was a difficult decision, as the boys had believed that this would be their 'forever family' and the move was reported to have had a significant impact on them.

If foster carers under stress are found to have treated children inappropriately, but in a manner which falls short of actual abuse or neglect, professionals face a dilemma similar to one they encounter when intervening to support and protect children living in their birth families. Should the child remain in that placement with (hopefully) the provision of additional support or, alternatively, should the child

and possibly others in the placement be removed? At what point does it become more harmful to leave children in placements than to remove them? This is a particularly difficult dilemma in relation to children apparently settled in long-term foster placements. On the one hand, children settled in long-term foster placements may suffer from disruption to their relationships with their carers but, on the other hand, professionals need to be confident that they will not experience further harm if they remain in the placement.

6.8 Conclusion

As we saw in Chapter 3, only a small proportion of fostered children are known to experience abuse or neglect in any one year. For these children, the abuse or neglect varies in nature and duration just as it does for other maltreated children. Some cases involved apparently one-off incidents, usually of physical abuse, some of which were relatively minor. In other cases physical, emotional or sexual abuse or neglect had persisted for long periods of time. Sexual abuse was identified in relatively few cases in this study but it was almost invariably very serious in nature and had often persisted undiscovered for years. In seven of the 10 cases of sexual abuse, the abuse only came to light after the child had left the placement.

In a number of cases there had been a pattern of previous, often minor, concerns that had not been taken seriously. Sometimes additional training and support had been provided, but the effectiveness of this support in improving the quality of care had not always been reviewed. As Utting's review of safeguards for children living away from home emphasised many years ago, it is essential to record all allegations on the foster carer's file so that any patterns can be detected (Utting, 1997).

There were examples of abuse or neglect in all types of placement: placements with kin or unrelated foster carers as well as in apparently settled long-term foster placements. There was some evidence that kinship placements were not always properly monitored and reviewed, so warning signs were missed, although this was also the case for a number of placements with unrelated carers. Wider research suggests that while standards for acceptable quality of care may be set lower for kinship carers, these may be offset by the durability of such placements and the benefits of keeping children in the family network. Outcomes also do not appear worse than for non-kinship foster care. Professionals may also be unwilling to disrupt apparently settled, long-term placements even where standards of care are questionable. However, in all placement settings poor standards of care should be addressed and professionals should remain alert to the fact that abuse or neglect may occur at any stage of placement.

The perpetrators of abuse or neglect included foster carers who were over-stretched or stressed for a range of personal reasons or who were simply struggling to cope with children's behaviour, which was often challenging. In some cases their personal circumstances had changed, for example due to their own or their partner's serious illness or a marital break-up, and they no longer had the capacity to provide high quality care for children. However in a small number of cases perpetrators were individuals who should never have been fostering: for example, those who subjected children to persistent emotional or sexual abuse. High quality assessment and effective review are needed to reduce the chance that such individuals become foster carers or, if they do, to ensure they are rapidly identified as unfit to foster. In a small number of cases the perpetrators of sexual abuse were the sons of foster carers.

As with abuse or neglect in any setting, good information sharing within and between agencies is also important. In several cases it was schools that raised concerns, although these were not always taken seriously. There may be a particular issue regarding information sharing when children from other local authorities are placed in Independent Fostering Agency placements, as the investigation of any concerns will be undertaken by the LADO (or other designated officer) in the host authority, not the placing authority (which may be some distance away). The LADO or other designated officer may be the most appropriate person to ensure that the agency employing the foster carer is notified of any concerns and also any local authorities who have children placed with that carer.

It is of course essential for social workers to see children regularly, and be alert to any indications they may give (explicitly or implicitly) that they are unhappy in a placement. Children should be seen both in the placement and away from it. It is concerning that in a number of cases children only disclosed the abuse or neglect after they had left the placement or while they were in respite care. Children will not always feel able to disclose that they are being harmed and, if they have experienced abuse or neglect before becoming looked after, some may not even realise that they have a right to expect better care. Seeing children regularly may build trust, but it may be difficult for children to develop trusting relationships with social workers when there is rapid staff turnover. However, in long-term foster placements there is a difficult balance to be struck between being alert to the possibility of poor quality care, abuse or neglect, and the need to avoid an overly-intrusive approach by social workers that undermines the capacity of such placements to provide children with normal family life.

Professionals cannot rely on children disclosing abuse or neglect at an early stage – or indeed at all. Empowering children to talk openly about their day-to-day life in the placement must be accompanied by other strategies. These should include good assessment, monitoring and review of placements. In a context of high staff turnover, management oversight and regular review are especially important. In this context it is also important for children's social workers and fostering social workers to look at the chronology of events and previous allegations.

6.9 Summary

- Abuse or neglect in foster care may range from one-off, relatively minor incidents of physical abuse by carers to serious and persistent physical, emotional or sexual abuse or – in fewer cases (in this study) – neglect.
- Although the number of children who were sexually abused in foster care was small, our study suggests that it may be particularly difficult to detect sexual abuse of this kind, as in the majority of these cases the abuse was only disclosed a considerable time after children had left the placement.
- There were examples of abuse or neglect in placements of all types and duration, including in apparently settled long-term foster placements and kinship care placements.
- There was some evidence that kinship care placements were not always properly monitored and reviewed so that warning signs were missed, although this was also the case for a number of placements with unrelated carers.
- The perpetrators included foster carers who were in some cases over-stretched or stressed for a range of personal reasons, or simply struggling to cope with children's behaviour, which was sometimes challenging. However, in a small number of cases the perpetrators were individuals who should never have been fostering, for example those who subjected children to persistent emotional or sexual abuse.
- In a number of cases there had been a pattern of minor concerns before the abuse or neglect was recognised. It is important to record all concerns raised so that it is possible to detect any emerging patterns.
- Social workers should see children regularly both in and out of the placements. However, not all children will feel able to disclose poor quality care, abuse or neglect.
- Good assessment, supervision and review of foster placements is essential and management oversight is important to ensure consistently good practice, particularly where there is high staff turnover.

Chapter 7

The abuse of young people in residential care

Chapter 1 outlined the long-standing concerns that have existed regarding the physical and sexual abuse of children in residential care. A series of abuse inquiries (from the 1960s to the 1990s) led to the English government commissioning a major review of safeguarding for children who are looked after away from home; this in fact contributed to the development of the *Quality Protects* initiative directed at driving up standards of public care (Department of Health, 1998a, Utting, 1997). Since then, as we have seen, there has been very little published evidence from which to gauge the extent to which the abuse of children by staff in residential settings may persist.

Published research has tended to focus on sexual abuse by peers in children's homes (Sinclair and Gibbs, 1998, Farmer and Pollock, 1998), on peer violence and bullying (Sinclair and Gibbs, 1998, Wade et al., 1998, Whitaker et al., 1998, Farmer and Pollock, 1998) and, reflecting more recent concerns about the 'grooming' of children, on their sexual exploitation by adults external to the placement (Berridge et al, forthcoming). However, this study has set out to explore whether abuse by residential staff continues to occur and, if it does, what forms it takes. Chapter 4 set out our findings for the UK on the occurrence of substantiated and unsubstantiated allegations in residential settings. This chapter explores the nature of abuse, drawing on a relatively small number of substantiated cases for which questionnaire data was received.

A total of 24 local authorities participated in Phase 2 of this study. However, only eight areas returned questionnaires for children in residential care. Of the 60 residential questionnaires that had been sent out, just 24 (40 per cent) were completed by the study deadline (31 March 2013), concerning a total of 28 children. The sample included six English authorities, one Scottish and one Welsh local authority. Therefore, while our Phase 1 survey included data on residential care from a representative sample of 156 local authorities, we cannot claim that our sample of 24 cases in Phase 2 is similarly representative. The data reported in this chapter should therefore be viewed as illustrative of the nature of abuse in residential care and the circumstances in which it is recorded. It is possible that, with a larger sample for Phase 2 of the study, we may have identified other forms of abuse occurring in this setting.

Some areas reported multiple allegations; others just one. Where multiple allegations were reported, these allegations tended to have arisen in different children's homes. The most from any area concerning a single unit was four cases. Most substantiated allegations concerned a single young person and only three cases involved more than one child.[47]

7.1 Characteristics of the children

Residential care tends to be reserved for older young people in the looked after system. It was therefore not surprising to find that these young people tended to be older than those in our foster care sample (see Chapter 5, Table 5.4). Eleven young people (50 per cent) were aged 15–17 at the time the relevant allegation was made; a further eight were aged 12–14 and only three were aged 11 or under.[48] A majority (17) were male. Where ethnic origin was reported (n=26), 22 were White, three were Black African-Caribbean and one young person was reported to be of mixed origin. Seventeen young people were reported to have no physical, sensory or learning impairments; two were reported to have a learning disability, and one young person was reported to be on the autistic spectrum.[49]

Although not specifically requested to do so, respondents reported that four young people had social, emotional and behavioural difficulties. This is likely to be an under-estimate, since the reported presence of these difficulties is known to be particularly high among the population of young people in care, especially residential care (Meltzer et al., 2003, Ford et al., 2007, Tarren-Sweeney, 2010). Indeed, these difficulties may lead young people to be placed in residential care, having experienced prior breakdowns in foster placements (Farmer et al., 2004, Sinclair et al., 2005b).

7.2 About the placement

Table 7.1 shows that just over one-half of young people were resident in children's homes at the time of the allegation and just over one-fifth each in residential education and secure accommodation. 'Other' represented a place at a shared care residential unit for disabled young people.

47 Two cases involved two young people and one involved three.
48 Dates of birth or dates of allegation were missing for six young people.
49 Seven cases were reported as "not known" by our respondents and one case was missing.

Table 7.1 Residential placement at time of allegation

Placement	Number (n=28)
Children's home	15
Residential education	6
Secure accommodation	6
Other	1

Just over two-fifths of these placements were provided by local authorities (43 per cent: n=12) and over one-third were provided by the private residential sector (36 per cent: n=10). Among those in secure accommodation, four separate allegations (involving five children) were from a single unit provided by H.M. Prison Service. The other secure unit was run by a local authority. Three separate allegations also arose in the same private residential education establishment.

Fifteen young people (54 per cent of the sample) were placed outside the boundary of the local authority responsible for their care. A large minority of young people were placed a considerable distance from home (see Table 7.2): over two-fifths more than 50 miles away.

Table 7.2 Distance of placement from child's home area

Placement	Number (n=28)
20 miles or less	8
21–50 miles	5
51–100 miles	10
More than 100 miles	2
Not known	3

Not surprisingly, given the regional nature of the secure estate, most of those in secure accommodation were placed more than 50 miles from home (five out of six), as were half of those placed in residential education (three out of six). Nearly one-half of those placed in children's homes (seven out of 15) were placed no more than 20 miles from home, although five were known to have been placed at a distance of more than 50 miles. Against a backdrop of the historic closure of local authority children's homes, it now appears to be more challenging for authorities to provide residential care close to children's birth families and home communities.

With respect to date of entry to this placement, information was only provided on 16 out of the 28 cases (and it was possible to calculate time in the placement prior to the allegation for only 13 young people) However, as Table 7.3 shows, most young people had been living in their residential placement for some considerable time before the allegation was made. At face value, therefore – and as we found for fostered children – placement duration does not appear to have a

bearing on the likelihood of an allegation being made. At least for this very small sample, it does not appear to be about the degree to which a young person is new to a placement, and therefore perhaps unsettled.

Table 7.3 Time in this residential placement before allegation was made

	Number (n=13)
Less than 2 years	5
2–5 years	5
6 or more years	3

7.3 Perpetrators of abuse

The subject of the allegation was generally a residential social worker (see Table 7.4). Where this was the case, the allegations mostly concerned male (15) rather than female workers (five). Allegations that involved another member of staff (n=2), included a male security staff member and a female teaching assistant, each of whom were found to have physically abused a young resident at their respective secure and residential education establishments. Although both young people continued to live in these units, the teaching assistant was dismissed after investigation, but the male staff member remained in employment, receiving additional support and training on the appropriate use of physical restraint.

Table 7.4 Who was the subject of this allegation?

Perpetrator	**Number (n=24)**
A residential worker	20
Another member of staff within the unit	2
Another young person resident in the placement	1
Another person	1

One child was the subject of an allegation and this concerned a 15-year-old female who had physically assaulted another female resident. As the comment below suggests, both had been involved in the altercation and the case was resolved through a meeting between both children's social workers, team managers and the private agency that managed the children's home. Most concern had centred on how residential staff had reacted to the situation rather than the situation itself. Both young women continued to live in the same placement:

> Two young people, both highly aroused emotionally. It was an incident that was over with very quickly, with the young person being seen as much an antagonist as a victim.

Finally, one allegation involved the disclosure of historic abuse by a male relative, the details of which were not provided. A 15-year-old female had lived in a private children's home for around 18 months. It was reported that she had felt able to talk about this past abuse for the first time because she now felt secure and had developed relationships of trust with members of the staff team. Apparently no further action was taken after this disclosure, but it is not clear why.

Two of these cases (not directly involving residential workers) had been classified as physical abuse. Looking at all 24 allegations, almost one-third were classified in this way (seven); a similar proportion (seven) were reported as physical restraint and two as emotional abuse (one of these in conjunction with physical restraint). No reports of sexual abuse were received and just one of neglect which, as we will see later , involved a neglect of duty to safeguard a child who was on the verge of running away. Four cases (one involving three children) were classified as 'poor standards of care' (falling short of actual abuse). Three cases were recorded as 'not known' and signify that the residential managers who completed the questionnaires were unable to classify them. The young female who reported historic familial abuse was also unclassified. These abuse clusters will be explored further below.

7.4 Abuse by residential staff

As shown earlier in Table 7.4, 20 instances of confirmed abuse or neglect were perpetrated by members of residential staff teams. Table 7.5 shows the different forms of abuse or neglect that were involved. In all but one case, where excessive physical restraint was associated with emotional abuse[50], multiple forms of abuse were not reported.

Table 7.5 Type of abuse or neglect by residential staff

Type of maltreatment	**Number (n=20)**
Physical abuse (not including physical restraint)	5
Excessive physical restraint (only)	6
Emotional abuse	2
Sexual abuse	0
Neglect	1
Poor standards of care (falling short of actual abuse)	4
Not known	3

50 This child appears twice in Table 7.5, so the number of instances totals 21.

With respect to outcomes for children, experiences of abuse rarely led to placement disruption. Only one child was known to have been removed from placement, and all other residents continued to live in the same placement. In only four cases was a formal looked after children review held to plan a way forward for the children involved, although some cases drew on joint meetings involving LADOs (or equivalent officers), social workers, children's services managers and residential teams.

Outcomes for residential staff were, understandably, much more variable (see Table 7.6). Only in five cases was no further action taken after investigation. In eight cases the responsible worker received additional support and training; one was transferred to another residential setting and three ultimately had their contracts of employment terminated. In addition, four workers were referred to the Independent Safeguarding Authority. In two of these cases, this led to termination. However, no further action was noted in the other two cases. There was no clearly discernible pattern in these cases that would account for these different outcomes. Similar kinds of actions and behaviour (as reported by our respondents) appeared to lead to different outcomes.

Table 7.6 Outcomes of substantiated allegations for residential staff

Type of maltreatment	Number (n=20)7
No further action	5
Provision of additional support, training and services	8
Referral to Independent Safeguarding Authority	4
Transfer to a different residential unit	1
Termination of employment	3
Subject to criminal prosecution	0
Not known	1

The rest of this chapter will explore these issues further by describing clusters of different types of abuse or neglect by residential staff identified in Table 7.5. One case, cited as neglect, involved a neglect of duty to provide adequate care by a female residential worker. A 14-year-old female was allowed to leave the premises knowing that she was planning to abscond. Although the young person did not make an allegation, the case was taken up by her residential manager as a fundamental breach of unit policy. The case resulted in the worker being referred to the Independent Safeguarding Authority and eventually dismissed:

> The staff member in question failed to provide adequate care and maintain unconditional care for the resident at the time. They knowingly allowed the young person to leave site without following or attempting to prevent them from leaving. This action was going against all of our homes policies, resulting in the staff member being suspended and then dismissed from her post.

While this case may be understood as involving a neglect of duty with respect to the policies and procedures of the home and demonstrating a poor standard of professional practice, it also points to the fluidity of the concept of neglect as sometimes applied to allegations. Although the girl may have placed herself at risk by leaving the home without permission, neglect usually carries the connotation of chronicity.

One case was cited as emotional abuse alone. The case involved a 15-year-old male of African origin who had lived for a year in a local children's home. A residential worker had associated the child's mental health and related behavioural problems to demonic possession and sought a spiritual solution. The child was removed immediately from placement and a looked after children review was held to plan his future. The final outcome for the worker was not known.

7.4.1 Physical abuse

Five cases were reported as physical abuse (not including physical restraint). In general terms, these cases centred on staff reacting inappropriately or with excessive physical force to episodes of challenging or provocative behaviour by residents in their care. One case, involving two females aged 14 and 15, arose in the early hours of the morning:

> Two young people were in one bedroom. Staff smelled burning and tried to enter the room to check. The two young people were aggressive and abusive and threw milk and water over a female worker. The worker then took hold of the two young people by their hair. She then let go immediately, went downstairs and contacted the police to tell them what had taken place. The whole incident was ongoing for about two hours with noise, abuse and threats directed at staff members who were attempting to reason with the young people and calm the situation down. Following the incident the young people were shocked by the actions of the worker but did say that they had provoked it. Their view was that they could understand why it had happened but that carers should not act like that.

Although there was a good deal of understanding of the pressures that residential staff may face in trying to manage and defuse conflict, it was also recognised that staff needed to be able to remain calm and reflective in high pressure situations:

> The worker had reached breaking point because of the targeted abuse of the young people. She could have taken a number of options to avoid escalating the situation. Staff really need to think about the impact of their actions and the consequences of their behaviours.

This worker was removed from duty during the course of the investigation, but the final outcome was not reported. In another case that did not result in suspension, the pressure of trying to prevent a young person from running away led to a worker kicking a bin that accidentally hit the young person. Although the young person was not injured, the case was investigated and the worker was advised as to their future conduct.

Finally, three separate allegations originated from a single private residential school. The detail provided on these cases was limited. All involved young males aged 14–16 over a period of two years and included staff members kicking out in anger, isolating a child in their own room and, in one case, carrying out "inappropriate physical interventions" on several occasions. Two of these cases resulted in termination of employment, the other in provision of advice, training and further support. In these scenarios, the exercise of physical violence was frequently associated with subsequent dismissal. In none of these cases had a looked after children review taken place to consider the implications of the incidents for these children's existing care plans. In some respects the cases echo patterns of historic physical abuse in children's homes, referred to in Chapter 1, that were the subject of a number of inquiries in the 1990s.

7.4.2 Physical restraint

As we saw in Chapter 1, physical restraint may be sanctioned, but only in exceptional circumstances where children place themselves or others at risk of significant harm. Six cases of excessive or inappropriate use of physical restraint by residential staff members were reported in this survey. The range of reported cases was quite broad. At one extreme, four separate allegations (concerning five young people aged 15–17) over a period of three months arose in a single unit for young offenders managed by H.M. Prison Service. The details provided were very brief. However it is clear that these instances of 'inappropriate physical intervention' were closely related to a unit culture described as being one of "physical compliance" and "physical domination". Although none of these staff members incurred further

action, which in itself is surprising, it was reported that the unit has subsequently been closed.

The other cases may be described as excessively rough handling of young people in circumstances where staff members were attempting to defuse conflict or restore order. In doing so, it was felt that they had reacted too strongly or breached unit policies. In one instance, for example, a young male aged 14 had been restrained while already on the floor, in breach of the policies for that unit. In these circumstances, criticism of staff reactions tended to be balanced by an understanding of the challenges presented to staff in managing heated moments such as these:

> The young person was restrained whilst on the floor due to presenting extremely aggressive behaviour. The departmental policy is clear that young people are not to be restrained in this way. However, the staff members were dealing with extreme behaviour and it was not felt that they intended to cause any physical harm to the young person but rather protect everyone and gain control of the situation.

The young person continued to live in the children's home and further training was provided to the staff team on the appropriate use of restraint. Our respondent highlighted the need for regular refreshment of the skills needed to safely defuse conflict situations:

> In terms of lessons learnt it highlighted the need to ensure that sfaff receive regular refresher training in dealing with challenging behaviour and also the need for staff to have more opportunity to reflect on practice and debrief following incidents.

All of these cases were managed internally after investigation, although one resulted in a referral to the Independent Safeguarding Authority. All of the young people continued to live in these residential placements and in no cases was there evidence that a looked after children review had been held. The importance of regular training to review and update the skills needed to manage challenging behaviour was the key issue highlighted. However, the findings also reinforce those from earlier research on residential care concerning the importance of a positive culture and strong leadership to provide a framework that can support good child care practice in children's homes and secure residential placements (see Berridge and Brodie, 1998, Sinclair and Gibbs, 1998, Brown et al., 1998, Wade et al., 1998). The promotion of positive relationships in residential settings and the development of principles of communal living to which young people can hopefully subscribe (and be involved in creating),

while by no means a panacea may help to provide a context in which strategies to safely manage conflict situations can be strengthened.

7.4.3 Poor standards of care

Four cases were identified by respondents as involving poor standards of care falling short of actual abuse. In some cases, however, the boundary between these classifications appears to be blurred. At one end of the spectrum, for example, a staff member was found to have used inappropriate language toward a young person who was acting out in the middle of the night. The staff member concerned apologised and received an advisory caution. Another incident bore parallels with the restraint cases above. In response to a violent outburst by a young person in a group setting, the staff member attempted to drag the young person away and restrain them rather than contain the situation *in situ*. On reflection, he was advised that it would have been better to disperse the group:

> The reaction of the care staff involved was affected by the felt need to move the young person to another location swiftly in order to reduce further conflicts. Staff need to look at alternative de-escalation options. Moving is not an option and the remainder of the group could have been moved.

Finally, while not straightforward to classify, the relationship between one staff member and a young person represented a clear breach of professional ethics. The complaint originated from this child's birth mother who, during her child's home visit, had found her son and his friends taking drugs which, it was suggested, had been supplied by his residential worker. The worker was immediately suspended and, after investigation, dismissed. The notion of 'poor standards of care' is therefore slippery. It may represent a continuum ranging from minor indiscretions through to forms of practice that break professional codes that are, in effect, indistinguishable from explicit and well-recognised abusive practices.

7.4.4 Unclassified cases

Overall, three cases were recorded as "not known". In these cases respondents felt unable to record any form of abuse or neglect. All of these cases had resulted in no further action against the staff members concerned, although unusually, each child had received a review or planning meeting to assess their future needs.

In one case, our respondent was certain that no abuse or neglect had taken place and that the allegation had been unprovoked. This concerned a five-year-old boy with mental health and behavioural problems who, according to this report, had been making multiple unwarranted allegations against various professionals at that time, including police officers, NVQ assessors, trades people and social workers. Another concerned a female residential worker who had inappropriately offered to provide supported lodgings in her home to a 15-year-old boy. She received corrective guidance, but no other action was forthcoming.

Finally, one case involved the use of physical restraint that was ultimately not considered to have been handled in an inappropriate manner. This concerned an attempt to prevent a 14-year-old female leaving a children's home late at night with a group of young people not known to residential staff. Once challenged, the girl responded violently and the staff member held her wrists in self-protection:

> The incident arose from the worker taking a stance to protect themselves from physical assault by the young person. The worker followed the crisis intervention training they had received. Other staff members were also present at the incident. The outcome of two strategy meetings identified that there was not a case to answer against the worker but there were significant concerns about the aggressive and offending behaviour of the young person that were considered at a separate planning meeting.

In response to these scenarios, this respondent emphasised that knowing the kinds of triggers that spark the behaviour of individual young people, discussing with them in calmer times the best ways of managing these moments and incorporating these strategies into their behaviour management plans would be beneficial to both workers and young people alike. It may also have the effect of reducing the likelihood that further allegations will be made.

7.5 Summary

- This chapter has provided information on a small follow-up sample of young people placed in residential care who were involved in allegations that were substantiated as abuse. Out of 24 local authorities that participated in Phase 2 of the study, eight returned residential questionnaires covering 24 allegations and involving 28 young people.

- Just over half of the young people were resident in children's homes at the time of the allegation, and just over one-fifth each were placed in residential education and secure accommodation. In relation to the latter, four allegations were from a single secure unit that had subsequently closed. Three separate allegations also arose from the same residential education establishment. The culture of physical compliance in these units carried echoes of past inquiries into historic abuse in children's homes from earlier decades.
- In most cases (20 out of 24) the subject of the allegation was a residential worker. Two cases involved other staff members (security or teaching staff); one an episode of violence by a young female resident, and the last an historic allegation of sexual abuse by a family member.
- Almost one-third of cases were classified as physical abuse (seven); a similar number related to the use of restraint (seven); four were reported as 'poor standards of care' falling short of actual abuse; two as involving emotional abuse, and three were unknown. No other cases of sexual abuse were reported. Multiple forms of abuse were rarely reported.
- Abuse rarely signified the need for a change of placement - only one child was permanently removed - and in most cases it did not lead to a formal review of events in the light of the child's existing care plan. For most young people, life was likely to have gone on pretty much as it had before.
- Outcomes for residential staff were more variable. Only five cases involving residential staff resulted in no further action; eight led to provision of additional support and training; three led to termination of employment, and four were referred to the ISA (two resulting in no further action). It was difficult to discern any clear pattern that would have accounted for these different outcomes.
- Cases concerning physical abuse or excessive restraint (the majority of substantiated allegations) tended to centre on staff reacting inappropriately or with excessive force to episodes of challenging or provocative behaviour by residents in their care. In contrast, a small number of cases concerned the absence of appropriate intervention to prevent young people going missing or leaving the home without permission. The findings highlight the challenges for residential staff in being able to stay calm and maintain authority when under intense pressure, and the importance of ongoing training to update and refine these skills.
- Some cases were classified as involving 'poor standards of care' short of actual abuse. While some did appear to involve minor indiscretions, the concept is a slippery one, as others appeared to involve behaviours that were quite indistinguishable from explicit and well-recognised abusive practices.

Chapter 8

Conclusion: messages for policy and practice

8.1 Introduction

The decision to separate children from their birth families is among the most difficult taken by social workers. It most frequently occurs when children have experienced abuse or other adversities within the family network. The purpose is to provide children with a period of safe care, to enable them to recover from their past experiences and to help them reshape their lives. For most children, the environment provided in foster or residential care is safe, and children and young people often say they think that the care they receive is good (Sinclair, 2005, Biehal et al., 2010, Wade et al., 2011a).

This study has focused on the minority of children and young people who do not always receive safe care and who, in some instances, experience further abuse at the hands of foster carers and residential workers responsible for ensuring their safety. Concern about historic abuse in children's homes has been longstanding, with a number of high-profile inquiries uncovering often systemic patterns of physical and/or sexual abuse of young people (see Stein, 2006, Sen et al., 2008). These concerns led to implementation of a series of safeguarding measures following reviews into safeguards for children living away from home (Kent, 1997; Utting, 1997). Since then, research evidence about the extent of current abuse in children's homes has been scarce. Encouragingly, recent studies of children's homes in the UK have not evidenced abuse by staff, although these studies did not have a particular focus on allegations (Berridge et al, 2008; Berridge et al, 2011; Berridge et al, 2012).

Very little is known about the extent and nature of abuse in foster care. While some surveys – often of unrepresentative samples of foster carers – have highlighted the impact of allegations on children, foster carers and their families (especially where these prove to be unfounded), evidence on the extent of abuse in foster care is lacking (see Biehal and Parry, 2010; Biehal, 2014). For example, there have been no previous UK studies of the incidence of confirmed abuse or neglect in foster care. For these reasons, this study collected data from a representative sample of social work agencies, rather than from foster carers, and its principal focus has been on confirmed rather than alleged abuse or neglect. Surveys of foster carers are unlikely to capture accurate information on confirmed abuse or neglect, not least because many of the foster carers concerned will no longer be

fostering. Foster carers' views on unproven allegations and the removal of children have been the focus of a number of previous UK studies, but were beyond the scope of this one.

Our study therefore set out to map this field for the first time and to answer a number of important questions. Looking across the UK as a whole, how frequently do allegations against foster carers and residential workers arise? Are there variations in the rate of allegations between local authorities or countries? What proportion of allegations is substantiated as abuse or neglect? Where this is the case, what kinds of behaviour or actions do these allegations encompass? What are the consequences for children and for those adults subject to allegations? Given the known distress caused by allegations to all concerned and the potential for further disruption to children's lives, these questions are of fundamental importance. This chapter will draw together our main findings and highlight, wherever possible, the key messages that arise from them for policy and practice.

8.2 The study

The study took place over a period of 12 months (July 2012–June 2013) and gathered data covering a three-year period. Phase 1 involved a UK-wide survey of all 211 local authorities to establish the total number of allegations (2009–2012) that were referred to LADOs (or equivalent officers) and, of these, the number that were substantiated, unsubstantiated (due to lack of evidence) or unfounded, and the number that resulted in children being removed from placement. A response rate of 74 per cent was achieved. The survey provides estimates of the annual incidence of total allegations and confirmed abuse or neglect of looked after children in residential and foster care.

Phase 2 focused on confirmed abuse or neglect. It involved a follow-up online survey of fostering and residential personnel in 24 local authorities, focusing on substantiated cases of abuse or neglect identified in Phase 1. Phase 2 yielded information on 87 fostering cases, concerning 118 children, and on 24 residential cases, concerning 28 children. Phase 2 generated exploratory findings on the characteristics of adults and children, the range of behaviours or actions concerned and the consequences of these for children and adults alike.

The study has some limitations that should be borne in mind. The Phase 2 sample is relatively small, especially in relation to residential care, and the findings from it should be considered indicative rather than conclusive. The study concerns allegations made against adult carers (or other adults linked to the placement) and to incidents arising *within* placements that were referred to LADOs (or their equivalents

in other UK countries). As such, the study excludes incidents occurring while children were away from placements; allegations concerning placement peers, and those that were not subject to formal investigation by LADOs.

8.3 Thresholds, definitions and recording systems

Obtaining accurate information on the annual number of allegations in each local authority proved to be challenging. At a national level there is currently no single source of national statistics that shows the total number of children affected by allegations in any UK country. Although all English local authorities are required to report on allegations to Ofsted each year (and most do), the information provided is of limited value in estimating the extent of child abuse or neglect in foster care. The published statistics report on the number of allegations against foster carers in a given year; on the support provided to them, and on outcomes of the investigation process. However, it does not provide evidence on the proportion of allegations that were substantiated (or not) nor on how many children were involved in these allegations. Moving forward, it will be important to consider the production of national child-focused statistics that help us to understand the extent of actual abuse or neglect in both foster and residential care.

Obtaining information directly from local authorities using a Freedom of Information request also revealed gaps in the information readily available to local authorities. First, not all local authorities participating in the survey operated a centralised electronic information system. In some areas, the requested information only existed in individual paper case-files, and non-compliance with our request resulted from concern about the time and resources required to aggregate it. Even where such systems existed, there was variation in the extent to which information on allegations was routinely collected and maintained as part of this system, and in the degree to which information on children and adult caregivers was integrated or held separately. In these circumstances a clear overall picture of the problem would be difficult to achieve, acting as a barrier to local strategic planning and development. Second, irrespective of differences in recording there were still quite large variations in the number of reported cases between local authorities, even among local authorities of a similar type and size. This pattern of variation suggests that there may be differences in how allegations are defined and in the thresholds at which referral and investigation are triggered.

In Chapter 2 we also saw that the lines of responsibility between local authorities for children placed out of authority could sometimes be confusing. In general terms, an allegation concerning a London child placed, for example, in the north of England would be managed by the host authority in which the placement is located. However, the extent to which the placing authority would be kept informed and would maintain records of the progress of this allegation appeared to be highly variable. In addition, the management of allegations between neighbouring local authorities was sometimes uncertain with respect to which areas took the lead on investigations. It is therefore important that clear structures and communication strategies are developed to ensure that the management of allegations is effective and that care planning for the child does not suffer. These relationships should also form a focus for future research studies in this area.

Key messages

At local authority and national levels aggregated statistical data on allegations are needed that are child-centred and can provide an accurate picture of substantiated abuse or neglect in foster and residential care.

Clear structures and communication strategies between local authorities are needed for children placed out of authority to ensure effective management of investigations and care planning for the children concerned.

8.4 Incidence of allegations in foster care

This study represents the first UK-wide survey of allegations of abuse or neglect of children in foster care. Information for three successive years (2009–2012) was obtained from 156 local authorities across the UK. The survey found that the vast majority of fostered children receive safe care, but that a very small minority suffer significant harm in these settings. On average, local authorities reported 10–11 allegations per area in each of the three years, giving an approximate UK estimate of 2,000–2,500 allegations per year, which equates to fewer than four allegations per 100 children in foster care across the UK each year. Between one-fifth and one-quarter of these allegations (22–23 per cent depending on the year) were confirmed as having constituted abuse or neglect, with an estimate of 450–550 confirmed cases of abuse or neglect in foster care in the UK each year, representing less than one confirmed allegation per 100 children in foster care across the UK each year. These findings are broadly consistent with those from an earlier UK survey of fostering agencies (Nixon and Verity, 1996).

Approximately three-quarters of all allegations were therefore not substantiated. Eighty-five local authorities were able to provide a more detailed breakdown on these numbers. In these areas, 26 per cent of allegations were confirmed as abuse or neglect; a further 30 per cent were proven to be unfounded; but another 43 per cent of all allegations were unsubstantiated due to a lack of evidence. These latter cases therefore frequently present real dilemmas for professionals attempting to decide on an appropriate course of action that will safeguard children in circumstances where clear evidence is lacking, though suspicions may remain. Children may be removed from placements quickly, when circumstances do not justify it, or remain in situations where they are exposed to further harm. Equally, foster carers who have done nothing wrong may see children removed or continue to live with the doubts of others surrounding them. The consequences for children and foster carers in these scenarios have been described in the literature (see Biehal and Parry, 2010).

In this study, where allegations were substantiated well over half of the children had been permanently removed from the placement (in 56–63 per cent of cases, depending on the year), amounting to approximately 300 confirmed cases per year across the UK that involved the removal of children. However, where allegations could not be substantiated, in well over one in 10 cases (13–16 per cent) the children were nonetheless removed. While this disruption to children's lives may have been fully justified in these cases, there is wider evidence of defensive, risk averse practices that can lead to the precipitate removal of children when allegations are made, without a balanced weighing of the risk to the child in decisions for them to stay or leave (Pearlman, 2012; Biehal, 2014).

There were significant variations in the total number of allegations and of confirmed cases of abuse or neglect between the different countries of the UK and, within England, between different local authorities. These patterns did not appear to be related to differences in the size of the fostered population in different areas. Further work is needed to understand fully this pattern of variance. While it may be true that the likelihood of abuse in foster care is lower in some areas, especially perhaps in some Scottish local authorities, it may also be that it partly reflects differences in definitions and in thresholds for investigation, in investigative and recording practices or, in some instances, in the extent to which some kinds of cases are (or are not) managed informally.

A conservative estimate (based on confirmed cases as a proportion of all fostered children in each country) suggests that abuse or neglect was confirmed for just under 1 per cent of fostered children in England (in each of the three years); just over 1 per cent in Wales, and for 0.1–0.2 per cent of fostered children in Scotland. These estimates are

broadly consistent with studies in the USA that have looked at the annual incidence of confirmed abuse or neglect in foster care, all of which established rates between 0.66 and 2 per cent (Bolton et al, 1981; Spencer and Knudson, 1992; Poertner et al, 1999; Billings and Moore, 2004).

It is encouraging to find that the vast majority of fostered children are provided with a safe care environment. Of course, this is as it should be. It is no less than should be expected. We should be mindful, however, that these figures are likely to slightly underestimate the true extent of abuse or neglect. As we have seen, our analysis here is based on allegations, a considerable number of which involved more than one child. Furthermore, while 22–23 per cent of all allegations were confirmed, many more were unsubstantiated because there was insufficient evidence to establish a case, and it is likely that a proportion of these children will also have been harmed by their experiences. Also, inevitably, our study was only able to collect information on *recorded* abuse or neglect, investigated by local authorities. So it is important for us to understand that the findings presented here establish only a minimum baseline estimate of abuse in foster care.

Key messages

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.

The grey area within allegations unsubstantiated due to a lack of evidence highlights the professional dilemmas facing practitioners when trying to decide on a safe course of action for the child and may lead to precipitate and disruptive action for child and foster carer. It is important that, where possible, time is taken (in conjunction with colleagues) to carefully weigh the evidence in individual cases.

Further work is needed to understand the variation that was found between countries and local authorities in rates of abuse or neglect to see the extent to which these are real or a product of different definitions, thresholds and practices. Similar findings are evident for residential care.

8.5 The nature of abuse in foster care

This study was able to describe the patterns and nature of confirmed abuse or neglect experienced by 118 children living in foster care. All forms of abuse or neglect were evident in our survey, including physical abuse (in 37 per cent of cases), emotional abuse (30 per cent), sexual abuse (11 per cent), and neglect (17 per cent). In addition, 15 cases were reported to concern poor standards of care falling short of actual abuse. Some cases involved apparently one-off incidents, usually of physical abuse, while others, especially sexual and emotional abuse or neglect, had often persisted over long periods of time. In some cases, especially concerning sexual abuse, the allegations were historic and only came to light sometime after the child concerned had left the placement. In comparison to child abuse or neglect in the family home, multiple forms of abuse were less common (see Wade et al, 2011; Ward et al, 2012).

Many of the foster carers (43 per cent) had been the subject of earlier allegations. In some instances patterns of previous, often minor, concerns had not been taken seriously or, where some training or support had been provided this had not been followed up to gauge its effects on quality of care. The importance of recording and taking seriously all allegations to detect emerging patterns of behaviour has been highlighted in government-sponsored reviews of safeguarding practice (Utting, 1997). We did find, however, that where suspicions had been aroused by awareness of past allegations, it was more likely that this particular allegation would result in the de-registration and/or criminal prosecution of the carers involved. Being alert to cumulative evidence of risk can therefore assist decision-making when new allegations arise.

The definitional boundary between behaviours recorded as 'poor standards of care' and those recorded as 'abusive' or 'neglectful' remains a grey area and it is likely that thresholds for defining behaviours as abusive vary between local authorities. It is therefore also important that previous concerns about poor standards of care are also taken into account when an allegation is made.

Abuse or neglect may occur in all placement contexts. There was little evidence to suggest that substantiated allegations were either more or less likely to arise, or that forms of abuse or neglect depended on the type of the placement: kinship or non-relative foster care; local authority or independent provider placement. However, many of these placements were long-term, with only one-quarter of children having been in placement for one year or less. Allegations may therefore occur at any point in the life of a placement.

There was evidence that warning signs may have been missed where children appeared to be settled in long-term placements and this is reinforced by the number of children who failed to disclose often very serious sexual and emotional abuse until after they had moved on. Wider evidence points to the potential vulnerability of children, especially younger children, in apparently settled placements where social work visits, monitoring and review are insufficient (Morris and Wheatley, 1994; Utting, 1997; Sinclair et al, 2007). It is understandable that professionals may be wary of disrupting such placements, perhaps especially where they are within the family network. However, if standards of care are known to be poor these should be adequately addressed and effectively monitored to ensure that children are properly safeguarded.

It is important for practitioners to be aware of signs of stress accumulation in foster carers. Some foster carers were evidently overstretched (taking on more children than they were approved to do or being required to mix very young children with older teenagers). Some were stressed by personal difficulties in their lives (family illness, marital breakdown, excessive alcohol use). All of these factors could reduce the capacity to provide good quality care and/or lead to the abuse or neglect of children in their care. However, in a smaller number of very serious cases involving the persistent emotional or sexual abuse of children, foster carers were operating who should never have been approved to foster. These individuals should be weeded out before they foster – or at the very earliest opportunity thereafter – through provision of high quality assessment, recruitment and review procedures. Where a decision is taken to terminate the approval of a foster carer (or would have been taken, if they had not resigned first) because they are considered to pose a risk of harm to children, the Disclosure and Barring Service must always be informed. In these circumstances, it is an offence to fail to make a referral without good reason (HM Government, 2013).

Communication and information sharing between agencies is also of obvious importance. There was evidence of initial concerns being raised (sometimes repeatedly) by schools, neighbours or other relatives; concerns that were not always taken seriously by social workers or acted upon. As we have seen, good communication channels are also needed between local authorities when children are placed out of area. Professionals cannot rely on children to disclose abuse or neglect, or even their unhappiness, at an early stage or even at all. Of course, it is vital that children are visited regularly, that they are listened to with care and empathy and that they are seen within and outside the placement. However, this alone is insufficient, and social workers need to be mindful of information passed to them by others and on their own powers of observation to assess the dynamics of placement relationships. This is inevitably more difficult to achieve when

staff turnover is high, where good records are not kept and when coordination between service providers is poor.

The balance that social workers need to strike between safeguarding children and the preservation of longer-term foster placements is a difficult one. The normalisation of family life, which is an important objective for long-term care, can be jeopardised by unnecessary and overly intrusive interventions. Judging when and how to intervene is a challenge. Over two-fifths of the children directly involved in substantiated allegations were removed from their placements immediately or soon after the allegation was made. A similar proportion of children in the same placements but not directly involved in the allegation were also removed at the same time. It was very rare for children to be removed at a later point, after the investigative process was completed, or, once removed, for them to return to the placement. Wherever it is considered safe to do so, a brief period of time spent weighing the risks involved in particular cases may help to reduce disruption to the lives of children and foster families. Pre-emptive permanent removal of children is one of the key complaints raised by foster carers (Nixon and Verity, 1996; The Fostering Network, 2004b; Swain, 2006).

The vast majority of substantiated allegations led to some form of further action against the foster carer(s) concerned. Only one in 10 received no further action; one-third of cases led to the provision of further support or training, and almost one-half to their de-registration. A small number of foster carers were subject to criminal prosecution and/or referral to the ISA. Although there was no association between these outcomes and the type of abuse suffered by their children, there was an association with whether or not the children remained living with them. Where the outcome involved no further action or support and training, it was considerably more likely that the child would stay.

Key messages

The findings emphasise the importance of continuous monitoring and review of foster placements by social workers. Abuse or neglect can occur in any kind of placement at any time, even where children have been settled for a long time.

Listening carefully to children, both inside and outside the placement, is essential. However, it is important to be mindful that some children may not feel able to disclose abuse until after they have left.

Good cooperation and communication between agencies and between local authorities (when children are placed out of area) is imperative for effective safeguarding practices. Without this, important signals of distress can be missed.

Past allegations and concerns about foster carers should be carefully recorded. Any new allegations that arise should be placed in historical context.

Like other people, some foster carers will experience periods of distress and personal difficulty in their lives. Although the vast majority will not go on to mistreat children in their care, these signs should not be ignored. Foster carers under stress should be provided with additional support, as provision of timely support may help to preserve the quality of care they provide.

Foster carers will also need access to good independent support and representation once an allegation is made.

Where a foster carer is removed because their actions or behaviour suggest they may pose a risk of harm to children, the Disclosure and Barring Service must be informed.

8.6 The incidence of allegations in residential care

Although there have been long-standing concerns about the physical and sexual abuse of children in residential care, evidenced by the large number of inquiries held into historic abuse, the few studies that have been undertaken in the UK on this theme have tended to be based on small and/or unrepresentative samples (Morris and Wheatley, 1994; Farmer and Pollock, 1998; Hobbs et al, 1999; Hutchinson, 2011). Until now, there has been no representative survey of the incidence of abuse in residential care across the UK.

Information on allegations in residential settings was sought for the same three year period (2009–2012). The survey was concerned with abuse by staff within these settings. As such, the survey did not include abuse by resident peers, abuse experienced while away from the home, by adults external to the placement or by family members during contact. As was the case with foster care, the findings revealed that most young people in residential care did not experience abuse from those charged with caring for them.

On average, local authorities reported five to seven allegations per area in each of the three years, giving an approximate UK estimate of 1,100–1,400 allegations per year, which equates to between 10 and 12 allegations per 100 children in residential care across the UK each year. Although the figures appear lower than those provided for foster care (2,000–2,500), they are proportionately higher once account is taken of the relative sizes of the foster and residential populations. Patterns of country variation were similar to those found for foster care, with higher rates of allegations and confirmed abuse in England and Wales and lower rates found in Scottish residential care. The reasons for these differences also require further exploration.

Between one-fifth and one-quarter of these allegations (21–23 per cent, depending on the year) were confirmed as having constituted abuse, with an estimate of 250–300 confirmed cases in residential settings across the UK, representing between two and three substantiated allegations per 100 children in residential care across the UK each year. So the proportion of allegations that are substantiated is broadly the same in both foster and residential care. However, abuse in residential settings may come to light more readily, since residential care takes place in relatively public settings, whereas fostering is located in the private domain of the family. Also, like foster care, at least three-quarters of allegations were unsubstantiated, either because they were unfounded or because insufficient evidence was available.

Unlike foster care, however, allegations (confirmed or otherwise) were much less likely to have led to young people being removed from the placement. Fewer than one in five substantiated allegations resulted in removal, and this applied to only a tiny number of young people involved in unsubstantiated allegations (0.4–2.4 per cent, depending on year). For most young people, therefore, residential placements endured.

Key messages

Residential staff teams do provide safe care to the vast majority of their young residents, although across the UK there are 250–300 confirmed cases of abuse in residential settings each year.

As with foster care, this is likely to underestimate the true extent of the problem and takes no account of abuse by peers or adults external to the placement.

Unlike foster care, confirmed abuse is much less likely to lead to young people being removed from residential placements.

8.7 The nature of abuse in residential care

While we have seen that most young people in residential units experience safe care, very little information has emerged in recent years about the nature of abusive practices. Through this study we have been able to report on substantiated allegations that concerned 28 young people, most of whom were teenagers.

Most young people were living in ordinary children's homes, with smaller numbers living in residential schools or secure units. Four allegations originated from a single secure unit that was subsequently closed down, and another three from a single residential education establishment. These units, in which there was some evidence of a culture of physical coercion and compliance, provided echoes of the establishments of the past in which cultures of systemic abuse were too often prevalent (see Stein, 2006).

Most perpetrators were members of residential staff and over half of the cases were classified as 'physical abuse' or as an 'excessive use of physical restraint'. No cases of sexual abuse in residential care were reported to us. The contours of physical abuse and restraint cases were broadly similar. In the main they centred on staff reacting inappropriately or with excessive physical force to episodes of challenging or provocative behaviour by residents in the home. They were generally reactive rather than planned.

Given the difficult histories and associated challenging behaviour of many young people placed in residential care, behaviour management is a complex and difficult area of practice. The provision of mental health services for young people in residential care may be inadequate, leaving staff to manage young people's difficult behaviour without the necessary professional expertise and advice (Davidson, 2010). Recent evidence from Scotland suggested that the practice of physically

restraining young people in residential units required improvement in at least half of the residential establishments in Scotland (Care Commission, 2008).

There was a good deal of understanding among respondents of the intense pressure that residential workers often face when conflicts erupt and the fragile balance of a unit is temporarily broken. However, there was also recognition of the need for practitioners to remain calm, maintain a sense of authority and to employ non-provocative strategies to defuse tensions in high-pressure situations. In this regard, the findings highlight the importance of good supervision and of ongoing training to update and refine skills and to develop appropriate reflective and debriefing strategies. They also reinforce findings from earlier research in residential care on the importance of a positive culture and strong (but consensual) leadership to provide a foundation for good child care practice in children's homes (Berridge and Brodie, 1998; Brown et al, 1998; Sinclair and Gibbs, 1998; Wade et al, 1998). Understanding the triggers that provoke individual young people and working with them on anger management strategies in calmer times may also help to reduce aggressive behaviour and improve staff responses. While these strategies will not guarantee success, they may contribute to an environment in which strategies to safely manage conflict situations can be strengthened.

A small number of cases were classified as 'poor standards of care' falling short of actual abuse. However, where the boundary lay between these classifications was not always clear. These cases ranged from minor indiscretions that could be corrected in a relatively straightforward way to significant breaches of professional conduct or forms of behaviour that were quite indistinguishable from explicit and well-recognised abusive practices.

As our UK-wide survey revealed, it was very rare for a substantiated allegation to result in young people being removed from the placement. It was also quite rare for it to lead to a formal looked after child review to situate events in the context of the overall care plan for the child. In many respects, then, life went on much as before.

Outcomes for residential workers were much more variable. While some cases resulted in no further action, others led to termination of employment or referral to the ISA. However, it was not possible to discern (at least from the data available to us) an explanation for these different outcomes. Similar kinds of difficulties could lead to different outcomes.

Key messages

The ability to maintain calm under pressure is essential when managing conflict and may be helped by positive training, support and supervision. In these ways practitioners may develop a repertoire of de-escalating strategies to reduce the tensions inherent in high-conflict situations.

Where children's homes work well, they tend to feature strong leadership, a positive culture that staff and young people are able to buy into, and to promote close inclusive relationships between staff and young people. Helping young people to find ways to manage their anger can help to reduce combustion within the home.

The inspection regime must weed out the small number of residential units that continue to maintain cultures of coercion and compliance, even where these are accommodating very challenging young people.

Where a member of staff (paid or voluntary) is removed because their actions or behaviour suggest they may pose a risk of harm to children, the Disclosure and Barring Service (previously ISA) must be informed.

8.8 Conclusion

Articles 19 and 20 of the UN Convention on the Rights of the Child emphasise the rights of all children to protection from abuse or exploitation, with special protection to be afforded to those children who have to be looked after away from home. Growing professional concern about the abuse of children living in residential settings led to a number of official inquiries from the 1990s onwards, although research evidence on abusive practices in the UK has continued to be scarce (Biehal and Parry, 2010). In a similar vein, very little has been known about the scale or nature of abuse in the rather more private world of foster care. This study represents an important first step on the road to understanding the extent, nature and consequences of abuse or neglect in foster and residential care. The findings are confined to allegations referred to LADOs or their equivalent officers in other UK countries. It does not, therefore, include abuse by resident peers or by adults external to placements, both of which have been of continuing concern, especially in residential care settings (see Kendrick, 1997).

In keeping with the UN Convention the vast majority of children who enter the public care system in the UK are afforded protection and most receive good quality care. However, a significant minority experience further harm at the hands of caregivers. Abuse or neglect arises in both residential and foster care. It may occur in any type of placement at any time. Turning away one's gaze from children apparently settled in long-term foster care is not acceptable: the misery experienced by unhappy children languishing in unsatisfactory foster placements is well described in the literature (see, for example, Sinclair et al., 2005b). In some cases there had been a number of lower-level concerns about foster carers, but incidents had apparently been viewed in isolation and patterns had not been identified. There really is no substitute for high quality supervision of frontline staff, for the effective monitoring and review of placements and for good cooperation and communication between agencies involved in the lives of children. With regard to these, the coordinating functions of Local Safeguarding Children's Boards, of Independent Reviewing Officers and of LADOs and their equivalents in other countries have a pivotal role in coordinating and monitoring services, ensuring the safety of children and undertaking investigations into allegations. Inter-agency communication is particularly important when abuse or neglect is identified in out-of-authority (private or voluntary sector) placements, to ensure that all other agencies using these placements are informed of the results of any investigations into foster carers or children's homes.

Children's homes are complex and fragile organisms, within which the balance of life can be easily disrupted. They have been shown to work best when they have strong leadership that is well supported and monitored by senior managers, where there is a culture of cooperation that is well understood and accepted by staff and residents, and where there are clear avenues for residents to raise concerns about the quality of care they receive. Abuse is more likely to occur where these features are lacking (see Berridge and Brodie, 1996).

Many of the inquiry reports into abuse in residential care have highlighted inadequacies in recruitment procedures (Kendrick, 1998). Strong selection and assessment procedures are needed to prevent individuals who may present harm to children becoming residential workers or foster carers. Foster carers also need good and realistic preparation at this stage about the risks involved in caring for children (some of whom may make unfounded allegations). However, some foster carers may not 'hear' the advice they are given on safer caring, or may think that it will never apply to them (see Wade et al., 2011b). Initial preparation therefore needs to be reinforced through opportunities for ongoing training to update and refine the skills needed for providing safe care. Greater access to specialist therapeutic support may also help residential staff and foster carers to better

manage the disturbed and challenging behaviour of some children and, in so doing, may reduce the risk of burn-out and stress-related abuse. Once an allegation is made, regulations and guidance specify the requirement for foster carers to be kept well informed about the progress of any investigation and for access to independent support to be made available (Department for Education, 2011c). However, the provision of these services has been uneven.

It is essential that both foster and residential care are underpinned by a child-centred, rights-based approach, which ensures that children and young people are listened to if they experience poor quality care, abuse or neglect. However, some children do make unfounded allegations. The reasons for doing so are complex. Furthermore, the confirmed abuse or neglect reported in this study ranged from minor indiscretions or failures to follow due procedure to the prolonged sexual and emotional abuse of children. Clearly, the same response does not fit all cases. Wherever it is considered safe to do so, it may help to reduce disruption to the lives of children and foster families if a little time is taken to review the allegation in context, taking account of past histories of foster carers and children, and in consultation with line managers and officers responsible for child protection. Precipitate action may not always be warranted, especially given that, once removed, children only very rarely return. In relation to more minor indiscretions, therefore, seeking solutions through negotiation may prove to be the most helpful approach for all concerned.

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