STIRLING COUNCIL - REVISED PART B RESPONSE

3. Retrospective Acknowledgment/Admission

3.1 Acknowledgment of Abuse

3.1 (a) Does the local authority accept that between 1930 and 17 December 2014 any children cared for in foster care were abused?

Yes.

(b) If so, what is the local authority's assessment of the extent and scale of such abuse?

On the basis of the evidence reviewed in preparing the section 21 responses, the Council considers that the extent and scale of such abuse was in line with reported prevalence rates at local authorities in the UK. The Council has identified that 62 children in foster care between 1930 and 2014 have made complaints of abuse. That is from a sample of 1,880 cases. The Council identified additional cases between the time of the original part B response and submission of the Part D response. A cautious approach was taken and any incident which it was considered might fall within the Inquiry's definition was included.

It is acknowledged that there will be other examples of complaints being documented within historic records which have not been found. It is also acknowledged that, in some instances, abuse may have occurred and there will be no record of it. However, on the evidence available to it, the Council considers that the extent and scale of abuse was broadly in line with the figures quoted by Professor Biehal in her report. On the basis of these figures, the Council identified a prevalence rate of 3.29% (62 complaints from 1,880 cases).

(c) What is the basis of that assessment?

In preparation for this phase of the Inquiry, the Council has reviewed a significant number of case files for children in foster care from 1930 to 2014. In excess of 2,500 social work files were reviewed. 1,880 cases of children in foster care between 1930 and 2014 were identified and reviewed. From this sample it was identified that 62 children had made complaints of abuse.

3.2 Acknowledgment of systemic failures

(a) Does the local authority accept that its systems failed to protect children in foster care between 1930 and 17 December 2014 from abuse?

Yes.

(b) What is the local authority's assessment of the extent of any such failures in its response?

In the late 1990s, a number of series failings in the Council's social work services were identified.

In 1998, an independent consultant, Sandy Jamieson, was commissioned to carry out an independent audit of a particular case which child protection concerns had been raised. This audit identified a number of "*serious concerns*" relating to children in the care of the authority. In order to ascertain whether the concerns were specific to the particular case, or of wider concern, Mr Jamieson was instructed to carry out a wider inspection of child care

services within Stirling Council. This inspection took place between February and March 1999. Mr Jamieson's report found that as a result of a number of deficiencies in the Children, Young People and Families Service the level of service in terms of quality of support given to vulnerable children in Stirling had, by the end of 1998, fallen below a safe standard.

Mr Jamieson produced two reports. The first was in relation to the specific household dated January 1999. The second, wider report was dated 6 April 1999. The reports themselves do not appear to have been widely shared – although historic minutes indicate that the findings of the reports were widely shared.

We have not been able to locate a copy of either report (a box containing papers including "*Sandy Jamieson repor*t" is noted to have been destroyed in 2005). We have however been able to locate references to the reports in minutes from the children's committee and the management team.

The children's committee minute of 22 June 1999 states that the review found that the service had deficiencies which included:

- Organisational and structural weaknesses particularly lack of professional supervision and lack of risk assessment.
- Lack of properly developed procedures
- Lack of specification of standards
- Inadequate supervision and support to staff
- A lack of a full range of foster carers to enable appropriate matches with children following risk assessment
- Revenue/funding shortfalls
- Shortages of front line personnel and management
- A failure to properly discharge the functions and duties of the Chief Social Work Officer
- A gap between the policies and strategies of the Council in relation to the care of children and the actual delivery of social work services for children.

A number of immediate actions were noted as having been taken (paragraph 4.11). Another consultant, Donal Giltinan (recently retired director of BAAF) was contracted to formulate a complete set of standards and procedures. A number of identifiable measures and actions were agreed which it was considered set out the basis for an improved service to be provided and monitored.

A further report on the necessary finance arrangements, to allow the necessary, identified changes to be made ("Children's services development fund report 22 June 1999") was presented to the Children's committee on 26 August 1999. The staffing issues which were identified at the time are later noted to have been largely cured by 1999 (see Children's committee minute of 19 June 2003).

(c) What is the basis of that assessment?

The Council's assessment is based upon the findings narrated in historic meeting minutes.

(d) What is the local authority's explanation for any such failures?

The lack of resources within the service was identified as one of the root causes of the problems. In 1996 the area team structure comprised 25 social workers in five teams under five managers. The consultant's view was that this was barely enough to provide a safe service. By 1998, this had reduced to 21 social workers in three teams under three area

managers. The consultant's view is noted in a minute of the children's committee of 19 June 2003, to be that this took the service below what could be described as safe in terms of supervision and support to staff and delivery of the service.

To put this in context, in March 1996, the Dunblane massacre took place. This occurred within Stirling Council's area. The consequences of the massacre required a significant amount of resource and placed enormous pressure upon the social work service and particularly the children's service.

From the available records, it appears that on disaggregation, Stirling Council adopted the policies and procedures of Central Regional Council and these were not updated or reviewed as they should have been. The reasons for this are not clear.

3.3 Acknowledgment of failures/ deficiencies in response

(a) Does the local authority accept that there were any failures and/or deficiencies in its response to abuse, and allegations of abuse, of children in foster care between 1930 and 17 December 2014?

No.

(b) What is the local authority's assessment of the extent of any such failures in its response?

We have not identified any such failures on the basis of the evidence reviewed.

(c) What is the basis of that assessment?

We had previously considered that there were potentially two cases (one in 1997 and one in 2010) where there may have been failures and/ or deficiencies in response to abuse or allegations of abuse. However, on further review of the records in relation to those cases, we concluded that the responses in each, once allegations of abuse had been made, were appropriate.

The first case around 1997/1998 involved an allegation of a foster child being slapped by his natural father. This was witnessed by a therapist. The foster child was accessing short break care. The social work department were made aware of the incident. A child protection investigation took place. A child protection plan was put in place. The child in question was already on the child protection register. Having reviewed the file, we consider that there was an appropriate response to the allegation.

The second case in 2010 involved an allegation that a foster carer had assaulted a foster child two years' previously by pulling him into a car and slapping him The foster child also alleged a male foster carer had pushed him on a bed in a caravan. When the allegation was made, a child protection investigation was carried out. The child was moved to another carer. There were two other foster children in the placement. Risk assessment and specific training were carried out. Criminal charges were brought against the female foster carer. She was found not guilty after trial. Again, having reviewed the file, we consider that there was an appropriate response to the allegation.

(d) What is the local authority's explanation for any such failures/ deficiencies?

As above.

3.4 Changes

(a) To what extent has the local authority implemented changes to its policies, procedures and practices as a result of any acknowledgment in relation to 3.1 – 3.3 above?

Numerous changes were implemented following the child protection investigation in 1998. These are outlined above and more fully narrated in the available meeting minutes. In particular an entire new set of policies, procedures and standards to replace the Central Regional Council policies were formulated in 1999, following on the independent consultant's report.

However, no specific policy changes have taken place as a result of the acknowledgments above. As part of overall learning from the Inquiry, Wendy McKitterick, Team Leader Adoption & Fostering, gave a presentation to the whole of children's services as a result of what she had learned when carrying out the work required to respond to the section 21 notice. The purpose of the presentation was to explain the work of the Inquiry to the wider service; to identify challenges in answering the section 21 response; and, particularly to identify the lessons learned.

The presentation identified a number of key themes including:

- Direct work with children to understand why they were in care was often absent.
- Files were not accessible for young people to understand.
- The language used in records was not always appropriate and demonstrated a lack of understanding about the impact of early experiences on children.
- Foster care assessments were not always analytical about the capacity of foster carers to understand care of young people who had experienced trauma.
- The voice of the child was often absent, particularly in earlier records.
- Records are a vital link to the past for children, and recording was not comprehensive.
- On disaggregation in 1996, it was evident that service records and policy information was not retained.

The Council strives to follow best practice and national standards at all times. The Council is currently in the process of engaging a policy officer to review all of its policies and procedures to ensure that they comply with the Promise.