

**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT  
HAMILTON**

Case No:

**Under the  
Fatal Accidents and Sudden Deaths  
Inquiry (Scotland) Act 1976**

**DETERMINATION**

**by**

**SHERIFF DAVID M BICKET  
Sheriff of South Strathclyde**

**following an Inquiry heard at the  
Glo Centre, Motherwell**

**into the circumstances of the death of**

**DAWN FIONA BYRNE McKENZIE**

**NOTE:**

Following on interlocutors of 29 April 2014 and 16 February 2015 it has been necessary to anonymise the names of certain children in this Determination and they are referred to simply as child D, child C, child S, and child K respectively. Other parties' names have also required to be anonymised to preserve the anonymity of these children.

[1] The sheriff having resumed consideration of the cause Determines that in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:-

1. Dawn Fiona Byrne McKenzie (date of birth 26 May 1977) (hereinafter "Mrs McKenzie") died at Hairmyres Hospital, East Kilbride on Friday, 24 June 2011

at 2140 hours. The incident which caused her death took place at her home address in Hamilton.

2. The cause of death was a stab wound to the abdomen, inflicted upon her by child D her foster child.
3. The death of Mrs McKenzie might have been avoided if Foster Care Associates Scotland (hereinafter FCAS), when considering if they had a suitable placement for child D when so requested to do so by Glasgow City Council (hereinafter GCC), had taken proper account of Mr and Mrs McKenzie's status as new carers, and lack of suitable prior experience of adolescent aged children such as child D and accordingly had not recommended them as suitable prospective carers for child D.
4. There were no defects in a system of working which contributed to the death of Mrs McKenzie.
5. Other facts which are relevant to the circumstances of the death are discussed hereafter under the following headings:-
  - (1) The Storage of Knives in the Foster Home Environment
  - (2) Crisis Prevention and Intervention Training
  - (3) Progression of Permanence
  - (4) The Role of the Children's Hearing System
  - (5) Provision of Information to Prospective Foster Carers
  - (6) Support of Foster Carers during Placement
  - (7) Management of Social Media
  - (8) Information about child D's Birth Father.

- (9) System of blanket age range approval with an age preference.

[2] Given the length of time that has passed since the tragic death of Mrs McKenzie and the various reviews that have been held since with consequent recommendations being largely implemented, recommendations have only been made by me in respect of three matters, although the recommendations of the Significant Case Review chaired by Mr Colin Anderson made to GCC and FCAS are included at pages 145 to 149 in the hope that they may further inform those reading this Determination.

### **The Background**

[3] The background to this Fatal Accident Inquiry was the tragic death of Mrs McKenzie as a result of injuries inflicted upon her by her foster child, child D. The said child was subsequently prosecuted and pled guilty to the culpable homicide of Mrs McKenzie. He was sentenced to an extended sentence of twelve years in the High Court in Edinburgh on 10 August 2012, the said sentence being composed of a custodial part of seven years detention followed by an extended period on licence of five years. He had originally been Indicted on a charge of murder but the Crown accepted a plea of guilty to the crime of culpable homicide on the basis of diminished responsibility. The charge to which he pleaded guilty was in the following terms:-

“On 24 June 2011 at ..... Hamilton you CHILD D did assault Dawn Fiona Byrne McKenzie, care of Hamilton Police Office, Hamilton, and did repeatedly stab her on the head and body with a knife and you did kill her.”

### **Statutory Framework**

[4] Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") sets out the purpose of an Inquiry in the following terms:-

**"6. - Sheriff's determination etc.**

(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction –

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death."

[5] An Inquiry of this nature does not determine any question of civil or criminal fault or liability as stated in the case of **Black v Scott Lithgow Ltd 1990 SLT 612** by Lord President Hope at page 615:-

"The function of a sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the sub section refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required".

[6] Also in terms of Section 4(7) of the 1976 Act rules of evidence shall be as nearly as possible those applicable in an ordinary civil cause brought before the sheriff. The standard of proof is the balance of probabilities and the facts and circumstances can be established without the necessity of corroboration.

### **Section 6 of the 1976 Act**

[7] I shall look now at the determinations which are available under the various subsections. The cause of death in this case was not an accident in the usual sense of the word, so I have used the word “incident” to replace “accident” in some places.

### **Section 6(1)(a) Date and Place of Death**

[8] It is quite clear in this case and accepted by all parties to the Inquiry that Mrs McKenzie died on Friday, 24 June 2011 at 2140 hours within Hairmyres Hospital, East Kilbride and that the incident which caused her death took place at her home address in Hamilton.

### **Section 6(1)(b) Cause of Death**

[9] The cause of death was a stab wound to her abdomen inflicted upon her by child D, her foster child.

### **Section 6(1)(c) The Reasonable Precautions, if any, whereby the death and any accident resulting in the death might have been avoided**

[10] What is envisaged by a “reasonable precaution”, is set out in **Carmichael on Sudden Deaths and Fatal Accident Inquiries (3<sup>rd</sup> Edition)** at paragraph 5-75, page 174 where it is stated:-

“What is envisaged is not a “probability” but a real or lively possibility that the death might have been avoided by the reasonable precaution”.

[11] Sheriff Ruth Anderson in her Determination into the circumstances of the death of Declan Hugh Hainey referred to four authorities in considering what constitutes a “lively possibility” which are helpful and these are as follows:-

1. In the Inquiry into the death of James McAlpine (October 1985) Sheriff

Kearney stated:-

“In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one”.

2. In his March 2004 Determination arising out of the death of John Kelly Sheriff

W Holligan stated:-

“It is not the function of an Inquiry to make findings of any fault or to apportion blame ... causation does have a role. In particular the provisions of section 6(1)(c) and (d) seem to me to proceed on the basis that there will be, in most cases, a process or event which falls to be examined in order to see what led to an accident. Having established such process or event, it is then possible to see what steps might have been taken to avoid the outcome or what defects there were. In my opinion, the provisions of section 6(1)(c) and (d) fall to be applied objectively and with the benefit of hindsight. Section 6(1)(e) gives some support to this interpretation. There might be circumstances that might be relevant to the death but might not have been established to have a causal link”.

3. Sheriff Ruxton in her 2014 Determination in the death of Catherine Beattie

stated:-

“... the term “might” should be applied in a sense that incorporates the notion of something qualitatively more than a remote possibility; a possibility with some substance and potential rather than a fanciful or notional possibility”.

4. In the Rose Park Inquiry Determination (20 April 2011) Sheriff Principal

Lockhart stated:-

“The question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference”.

[12] I have considered all the evidence led in the course of this Inquiry including the evidence of the various changes in policy and procedures which have occurred since the tragic death of Mrs McKenzie and have come to the view that the precaution which I have identified in terms of Section 6(1)(c) is a reasonable precaution which had it been taken might have avoided the death of Mrs McKenzie on 24 June 2011. I have discussed the reasons for that fully at pages 101 to 111 in the Note appended hereto.

**Determination under Section 6(1)(d)**

[13] The Crown urged that I find that the system of blanket age range approval for foster carers with an age preference also expressed, which was in use by FCAS caused a degree of uncertainty and potential confusion and constituted in this case a defective system of working which contributed to Mrs McKenzie’s death. Ms Dowdalls for GCC submitted that there was no evidence to support the proposition that there was a defect in any system of work for which GCC were responsible which caused or contributed to the death. As discussed in the Note I am prepared to accept that.

[14] Such a finding was also resisted by Mr Macpherson for FCAS, on the basis that the decision to make this placement was not a system of working, it was a decision within a

system of working and that the decision itself even if wrong could not give rise to a finding under Section 6(1)(d).

[15] In the broad sense, for reasons I have discussed fully at pages 137 to 144 in the Note appended hereto, I find myself in agreement with Mr Macpherson's submission. The system of blanket age range approval with an age preference also expressed does not in itself appear to me to be a defect in the system of working which contributed to the death – but it is clearly important that there is a rigorous examination of the age range approval, and preference, if any is expressed, in the application of the matching process. Accordingly I have dealt with this matter fully under Section 6(1)(e) as it does appear to me to be worthy of comment and I have made a recommendation in this regard under that paragraph.

#### **Determination under Section 6(1)(e)**

[16] So far as Section 6(1)(e) is concerned this has already been judicially considered by Sheriff W Holligan in his Inquiry into the death of John Kelly where he stated:-

“The provisions of section 6(1)(e) are still wider, and in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the Inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation”.

[17] In this section I have identified nine matters which I consider of relevance and in respect of three of these I have made recommendations. These are discussed fully in the Note appended hereto at pages 111 to 145 hereof.

#### **The Inquiry**

[18] This Inquiry was first scheduled to commence on 17 September 2014 but was unable to do so because at that stage an Expert Report commissioned by the Crown was not available. The Inquiry had to be subsequently adjourned after a number of procedural hearings and eventually evidence commenced on 16 February 2015 and was heard over thirty non-consecutive days until 5 May 2015. After the conclusion of evidence, parties were requested to produce written submissions and the Procurator Fiscal very helpfully produced a Draft Statement of Facts and circulated that to the other parties in the Inquiry enabling them to add comments to their submissions and focus the disputed areas. I have made use of that Statement of Facts in my own Findings in Fact which are inevitably lengthy given the many areas that were covered in the course of the Inquiry. I consider it important that the evidence upon which my Determination proceeds should fully be set out, and have expanded on matters in my Note where appropriate to do so. Findings in Fact have been collected under the headings utilised by the Procurator Fiscal. Inevitably there is some overlap and some occasional repetition. A hearing on submissions took place on 29 June 2015.

## **Findings in Fact**

### **Child D's Personal History and Family Background**

1. Child D was born on 1 June 1998. He is the fourth of six children of MC (otherwise known as McC), born 13 February 1972.
2. Child D has five half siblings, namely child K (born 23 December 1989), child J (born 16 October 1992), child R (born 19 April 1994), child C (born 17 March 2002) and child S (born 27 October 2004).

3. Child D and his three half- brothers all have a different man registered as their father on their birth certificates. Children C and S both have RR (born 19 June 1969) registered as their father on their birth certificates.
4. RR has three older daughters from a previous relationship.
5. The mother of MC, EMcC, lived in the same block of flats in Sighthill, Glasgow, as MC, RR and the children, prior to children D, C and S being accommodated.
6. MC had a difficult and traumatic childhood. She and her sister were sexually abused by their stepfather and MC's relationship with her mother had been badly affected as MC blamed her mother for failing to protect her. By the time she was 22 years old, MC had three children under 5 years old, all of whom had different fathers. Despite the difficulties in the relationship between MC and her mother, child K, the eldest child, was regularly looked after by his grandmother.
7. When MC and her partner DD separated after child D's birth, DD went on to have a relationship with MC's mother, which caused a further rift. MC has since said that DD is not child D's biological father, although DD is named as the father on child D's birth certificate.
8. MC has stated that a JO is child D's biological father.
9. MC and her children had numerous moves of house and area before children D, C and S were accommodated.
10. RR also had a difficult childhood. He has a lengthy history of offending and has served numerous prison sentences. He has been convicted of road traffic offences, crimes of dishonesty and latterly, drug related offences.

**Child D's Early Childhood (prior to being put on Child Protection Register in October 2003)**

11. By the time Royston Social Work Department became involved with the family in 2002, MC and RR had been a couple for around three years. The family had moved to Inverness and back twice, where social work services had been involved. Child K and child J had both been accommodated for short periods both in Glasgow and Inverness because their mother was not coping. By that time, there were five children in the family, with child D aged 4, having three older half-brothers, child K, child J and child R, and a baby half-sister child C. The family appeared quite settled in Glasgow.
12. Child K was not always in the household as he sometimes resided in Inverness with family there. MC was assessed as having adequate parenting skills with the younger children, so the focus of the attention was the poor and deteriorating behaviour of child J and child R. Child J and child R were placed on home supervision requirements in March 2003.

**Period when Child D was on The Child Protection Register prior to accommodation**

13. Concerns about the welfare of the MC/RR children, the state of the house, aggressive family interactions and the anti-social behaviour of the older boys, which by this time was being copied by child D, led to the children's names being placed on the Child Protection Register on 6 October 2003. They remained registered for three years, until October 2006.
14. Child J and child R were accommodated on a voluntary basis on 18 November 2003, but were returned home on 12 December 2003, because the placement broke down and there were no suitable alternative placements. However, MC could not cope with them and they were accommodated again within days, with child J going to a children's unit and then onto a residential until in August 2005, where he remained for four years. Child R was put in a family based placement, but he was returned

to his mother in July 2004 when his placement broke down and his mother refused to agree to him being accommodated at a residential resource.

15. In April 2004, the case was allocated to Cameron Knox and Cornelius Ehimiaghe, social workers, who shared responsibility for the case. Child S was born in October 2004 and was allocated to Cornelius Ehimiaghe in January 2005. Prior to that child S had not been allocated to a named worker. From March 2005, Cornelius Ehimiaghe took on responsibility for the whole case.
16. The focus of Social Work Department concerns continued to be the behaviour of the older boys. The level of aggression between and amongst the children was very worrying, particularly the aggression and violence of child R towards child D, which he reacted to by hitting out, mainly at his younger sisters. Child R was frequently violent towards child D and there was concern about the fact that child D would follow child R around and emulate his anti-social behaviour. Indeed, the anti-social behaviour of the boys put the family tenancy in jeopardy. The Social Work Department was concerned that MC could not maintain control or care of her children, particularly as they grew older and their behaviour became more challenging, and was also concerned that MC was isolated within the community with little support from family. A variety of further concerns were raised, including in November 2004, when child D claimed that he had been bitten by a rat, but MC had not sought medical attention for him when told, and ongoing concerns about the children often being hours late for school, despite the fact that they lived next door.
17. In March 2006, Janet Smith, social worker, was allocated responsibility for child R, and children D, C and S, with Cornelius Ehimiaghe remaining the allocated worker for child J. These two workers had different line managers. Rikki Laird, Practice Team Leader, who retained responsibility for the case for three years, was the line manager for Janet Smith, and the subsequently allocated social workers Scott McCabe and Wilma Dale.

18. Janet Smith took responsibility and changed how the case was managed.

Considerable effort was put into improving conditions for the children through a range of actions, including financial help from the Social Work Department and charitable sources to buy essential household equipment to improve physical conditions in the house. MC was referred to a counselling service to get help to address her own problems. A referral was made to the Forensic Child and Adolescent Mental Health Service (FCAMHS) for child D, support from Includem and respite care was sought. The Ruchill Support Project attempted to work with the family and Home Support was provided in an effort to support child C's attendance at nursery.

19. Up to this point, RR had not had significant involvement in the work done with the family as MC kept RR away from most of the childcare duties as she preferred to do them herself. He either stayed in the bedroom when workers visited, or left the property when they arrived. Janet Smith worked hard at engaging with RR, even arranging a child protection core group meeting in HMP Barlinnie in order to involve him. He was visited by both Janet Smith and Rikki Laird while in prison, and contact between RR and the children in prison was also facilitated.

20. On 6 May 2006, MC visited RR in prison when it was discovered that she had concealed heroin in child S's clothing. She was arrested and the children were at that time looked after by members of the extended family. The police searched the family home, and found drugs in one of the children's bedrooms. RR subsequently admitted drug dealing from the family home. At that time the family home was in very poor condition. The property was very untidy and dirty. There were piles of clothes lying around and it was not clear where the children slept. The cot was full of rubbish. The kitchen was dirty and the work surfaces were piled up and could not be used to prepare food. There were knives lying about as well as razor blades. A number of electrical sockets were loose and there were exposed wires. There was an iron left on and it was unsafe. There were dog faeces on the floor.

21. On 16 May 2006, a Child Protection Case Conference review took place. As a result children R, D and C continued to be registered on the Child Protection Register and child S was also registered at this time. Child S had not previously been brought to a Child Protection Case Conference. The decision was made that MC had three months to turn around the family situation or all four children would be accommodated.
22. In August 2006, RR was released from prison, and MC started her sentence, at which time RR had care of the children. The Social Work Department gave financial assistance which allowed MC's sister to come from Inverness to assist with care of the children. There were continual issues in relation to the anti-social behaviour of the children, including child D, causing a serious risk of the family losing their tenancy. MC was released from prison in September 2006.
23. By 6 November 2006, it was assessed that there had been a "dramatic improvement" and the Child Protection Case review removed the names of the children from the Child Protection Register. The house was in a better state and the housing provider had reported *some* improvement. Within a very short period, however, the perceived improvements had fallen away.
24. Janet Smith left her post at the start of 2007 and the case was not reallocated to a named worker. The case did, however, remain within the same team and was still supervised by Practice Team Leader Rikki Laird. Any issues arising were dealt with by staff members within Rikki Laird's team or by Rikki Laird himself.
25. Wilma Dale, social worker, was allocated the case in May 2007. She had assisted with home visits prior to formal allocation and therefore had knowledge of the family. At the point of allocation, child R and child D's anti-social behaviour was not improving and child S had not been in nursery for weeks. Child R slept on a dirty sofa in the living room and child D slept on a small child's trampoline.

Wilma Dale considered that there had been no real improvement in conditions for the children, that the previous assessment of the family circumstances had been overly optimistic, and that at this time the children should be accommodated.

26. On 13 June 2007, a Child Protection Conference was convened. Child R and children D, C and S's names were put back on the Child Protection Register. At this time Kevin Brown, Operations Manager, commissioned Wilma Dale to carry out a Neglect Assessment on the family. The assessment concluded that the children were in the highest category of risk of neglect in all areas of their lives.
27. After 13 June 2007, regular core group meetings were held and the children were visited weekly by social work staff. Wilma Dale reported that while MC would on occasion seek support, she would then not accept it when offered by the Social Work Department. MC did not impose boundaries and routine in the children's lives. Nor did she get any support from RR in relation to the children.
28. Following a referral made by the Social Work Department child D was offered a place on the SNAP programme ("Stop Now And Plan"), a programme designed to enable 6 to 12 year olds with emotional difficulties to think about and reflect upon their emotions and behaviours. The programme is a parenting and child treatment programme which focused on risk factors associated with future offending and future violence in childhood. For example, where a child is impulsive or displaying reckless behaviour, or where the parent is having difficulty controlling behaviour where the child is angry and has struggled to coped with anger problems, the programme teaches self- management strategies and self-coping strategies, for example how to stop and think before taking an action. The programme requires the input of a parent, to work with the child to address behaviours and set boundaries. Child D was assessed as being a suitable candidate, but MC failed to engage with the programme, therefore he was unable to participate.

29. From July 2007 onwards, while Wilma Dale was still the allocated social worker for the children, it was decided by the Social Work Department that Scott McCabe would attend home visits with her as a result of the level of aggression being directed at social workers by the parents.
30. In mid-October 2007, the Social Work Department was alerted to CCTV evidence of child C, at this time aged 5 years, wandering outside alone in the middle of a cold autumn night.
31. On 8 April 2008, Childline received a telephone call from a person who had concerns about the wellbeing of children C and S, reporting that they had attended the caller's door wearing only pyjamas. When the caller returned the children to their home, threats of violence were made to the children by three unidentified adults. The matter was referred to the Social Work Department. Wilma Dale and Scott McCabe visited the parents at the family home to address the concerns. RR was aggressive and dismissive and MC completely unfazed by what had happened.

#### **Circumstances of Accommodation by the Local Authority**

32. A case review conference was held on 5 November 2007. This review was attended by representatives from education, housing, health, Includem and the parents. It was decided at this review that it should be recommended to a children's hearing that children D, C and S should be accommodated in a foster care placement on the basis of ongoing and longstanding concerns. These concerns included the inability of the parents to maintain routines and boundaries for the children, the level of aggression between the children, in particular concern about child R's ongoing aggression towards child D, anti-social and sometimes criminal behaviour of child R and child D in the community, the ongoing dirty and unhygienic state of the family home, the fact that some of the children did not have a bed to sleep on, the fact that the children presented as hungry, tired, dirty and late to school, the impact of that on the ability of the children to learn properly, aggressive behaviour

at school, lack of routine for eating in the family home, concerns in relation to safety, lack of supervision, drug related activity taking place in the family home, failure of the parents to take the children to all relevant medical and other appointments, and failure of parents to engage with efforts of the Social Work Department to enable them to improve the circumstances of the children.

33. On 15 November 2007, a children's hearing was convened at which the grounds for referral were not accepted by the parents and deemed to be not understood by children D, C and S and not accepted by child R. The grounds were referred to the Sheriff for proof. The children's hearing decided by majority not to issue a Place of Safety warrant sought in respect of the children, because they thought that the children were not in immediate danger, the parents clearly loved their children and demonstrated a good bond with them throughout the hearing, and some minor improvements had been made recently in terms of child R's progress at Includem and around the home. MC and RR told the panel that they would do anything for their children and promised to cooperate with the Social Work Department. The position of the Social Work Department at this time was that they had undertaken many times before, over a period of years, to engage with services and make changes for the benefit of the children, and had consistently failed to do so.
34. On 6 February 2008, a review case conference for the children was convened. MC and RR failed to attend. After discussion, it was decided that a further review should take place prior to the next children's hearing in order to give the clear recommendation to the panel that the children should be accommodated.
35. On 7 March 2008, grounds for referral in terms of s52(c) of the Children (Scotland) Act 1995 were established at Glasgow Sheriff Court. The established grounds in relation to children D, C and S included statements that the family home was dirty and untidy, that the children had to sleep on mattresses or the settee, that the kitchen was dirty and unhygienic with bags of rubbish on the floor and old scraps of food strewn about, that RR had a history of drug misuse, that MC had

previously taken heroin into HMP Barlinnie, concealed within child S's clothing, that child C had been observed on various occasions to be outwith the family home without supervision, that child D presented at school late, tired and hungry, that child C was often very late to school and had subsequently fallen asleep in class, that child D and child R's behaviour in the community was bringing them to the attention of the police and putting the family tenancy at risk and that MC was not engaging with a variety of services offered by a variety of agencies.

36. The Social Work Department Area Team contacted Placement Services in order to seek a placement for children D, C and S. It was not possible to find a GCC placement for the children. Authority was sought and granted by Kevin Brown, Operations Manager, for a purchased placement to be sought. Purchased placements are placements that are sourced from independent fostering agencies. At this time the Social Work Department sought to keep the three children in a placement together, on the basis that it was in their best interests to do so. Placement Services sourced a placement with M and D McA, foster carers for FCAS. GCC Placement Services sourced the placement by first contacting FCAS, who identified M and D McA as suitable carers.
37. In terms of social work practice, the Social Work Department operates on the principle that accommodated siblings should be kept together in placements where possible, unless there is a specific reason for them to be separated.
38. On 8 May 2008, the Social Work Department, represented by Wilma Dale and Rikki Laird, Practice Team Leader, recommended to a children's hearing that children D, C and S be accommodated by the local authority. The hearing, by majority, decided that a Safeguarder should be appointed and then accommodated the three children under a Place of Safety warrant at the request of the Social Work Department. The concerns of the children's hearing that caused it to issue a warrant related to the established grounds of referral, including concerns in relation to failure of the children to thrive, behavioural issues, issues surrounding

getting routines in place and concerns about the children's education. MC and RR became very aggressive and threatening in their demeanour after this decision was made, and ultimately police officers had to intervene to calm the situation.

39. Children D, C and S were placed with Mr and Mrs McA as a result of the children's hearing decision on 8 May 2008. The children were moved to the placement the same day.
40. The Place of Safety warrant was reviewed 21 days later, on 29 May 2008, and at the review hearing a condition of supervised contact with the parents was made, set at a minimum of twice per week. The warrant was continued for a further 21 days, until 17 June 2008, at which time the warrant was renewed again.
41. On 8 July 2008, after receiving the Safeguarder report, the children's hearing made a supervision requirement in relation to children D, C and S, with a condition of residence with Mr and Mrs McA and a condition that the children would have contact with MC and RR twice weekly, for a minimum of two hours.
42. On 15 September 2008, Scott McCabe, social worker, formally took over responsibility for the case from Wilma Dale. She had been receiving ongoing threats and had been intimidated by family members, particularly RR, over a sustained period of time and her position as the children's social worker had become untenable. Between 8 May 2008, when the children were accommodated, and 15 September 2008, Scott McCabe had been involved in transporting the children to and from contact sessions and supervising contact sessions.
43. On 9 October 2008, the children's names were removed from the Child Protection Register, on the basis that they were now accommodated.

#### **Placement with M and D McA**

44. Approximately one week before the children's hearing of 8 May 2008, M and D McA, foster carers, were approached in relation to the possibility of fostering child D and his half-sisters. They met with representatives of FCAS, their employer, and GCC Social Work Department, to discuss the potential placement. They were given information in relation to the children's background and the reasons why the Social Work Department was seeking to accommodate the children. Mrs McA considered that sufficient and full information was given to allow them to decide to agree to the placement. This information included practical information about the children, including that child D at that time frequently wet the bed.
45. Children D, C and S were placed with M and D McA on 8 May 2008, after a children's hearing decided that the children should be subject to a Place of Safety warrant.
46. M and D McA were both full time foster carers for FCAS, having been approved in 2003. They already had a young male foster child in placement, who was due to return home within a short period. Mr and Mrs McA, temporarily had their approval increased to allow them to accommodate four children in the interim period.
47. The children continued to attend school and nursery in Sighthill, Glasgow, notwithstanding the fact that they now resided a 50 minute car journey away.
48. During this placement child D and his half-sisters had twice weekly contact with MC and RR, mainly in Royston social work office. Contact was described by supervising social work staff as "chaotic". Often MC and RR would arrive late, causing anxiety to the children. RR on numerous occasions failed to attend offering no explanation to the children for his failure to do so. MC and RR had no control over the children, failing to be able to engage them for any sustained period of time. The children would at times run along corridors, scream for attention and be aggressive towards each other and towards RR. Social workers were concerned

that child D would not receive as much attention or affection as the girls, and would at times be scapegoated for the fact that the children were in care, being told that it was his fault that they had been accommodated. RR would on occasion raise his voice towards the children when their behaviour became challenging, thereby escalating the situation. The ends of the contact sessions were consistently distressing for the children and difficult for the social work staff, this being exacerbated by the behaviour of the parents who would not take the advice of social work staff in relation to how best to part company with the children. The allocated social worker, Scott McCabe, was concerned that the contact was distressing for the children and was causing them harm.

49. By September 2008, Scott McCabe had made various referrals, including a referral to the Family Contact Service. The Social Work Department was still considering rehabilitation of the children D, C and S back to the care of MC and RR. Despite the ongoing efforts of the Social Work Department, there was, however, no improvement in the quality of the contact for the children and the parents refused to cooperate with the Social Work Department, denying that they were responsible for any of the problems or difficulties that led to the children being accommodated, and indeed denying that there were any problems in relation to the children.
50. On 31 October 2008 the children's hearing did not agree to the social work recommendation to have contact between the children and parents reduced, and for the children to be permitted to change school and nursery, in order that they could attend local establishments. The supervision requirement was continued without variation. MC and RR presented as highly emotional and blamed the Social Work Department for the situation. They said that they would do whatever was necessary in order to ensure that the children were returned to them. The Deputy Head Teacher of the children D and C's school reported a significant improvement in their attendance and presentation since they moved to foster care, but indicated that there were still behavioural issues. The Social Work Department informed the hearing that MC and RR were not cooperating with the care plan,

that they still disputed the established grounds for referral and that MC was attending contact sessions but not other appointments. MC and RR had not cooperated with Social Work Department despite the fact that they had said that they would do so. RR stated that he would not cooperate with the ongoing assessment of his offending, drug and alcohol misuse and parenting skills.

51. On 30 January 2009, a Permanence Review was held by the Social Work Department. Present were representatives from the Social Work Department, FCAS, the Family Contact Service, the primary school, the child S's nursery and MC. The Review was chaired by Kevin Brown. The decision of the review was that rehabilitation of MC and RR was no longer under consideration and that permanence was to be pursued. Long term arrangements were to be made for the care of the children and the Social Work Department was to pursue a phased reduction in contact with MC and RR in accordance with the needs of the children. Written advice from the Legal Services Department was to be sought. The possibility of adoption for the children C and S was being considered, and long term fostering for child D, although Kevin Brown's view at this time was that the children should remain together if possible. Kevin Brown also considered that adoption would not have been a realistic possibility for all three children, in terms of resources, and that it would not in any event have been in the best interests of the children as some level of contact with the birth family was likely to continue. A Parental Responsibilities Order was also under consideration. Moving the children to local educational establishments was also to continue to be pursued.
52. Following the Permanence Review, on 30 January 2009, Scott McCabe referred the case to the Legal Services Department of GCC, which responded on 2 February 2009 with a detailed note in relation to progressing the case for permanence.
53. On 5 February 2009, a referral was made by the Social Work Department to LAAC Mental Health Team, following recognition that child D's emotional and behavioural development had been significantly impacted upon, despite there

being some progress within the placement environment. Scott McCabe acknowledged that child D did respond to the consistent boundaries and nurturing within the placement, but significant difficulties remained, and he continued to be challenging and defiant while at contact, with negative attention from MC and RR persisting.

54. It became clear on 9 February 2009 that RR knew the address of the placement, which was not, as stated in children's hearing decisions, to be disclosed, when he started shouting in the street after a contact session that his children were not safe at the placement and told Scott McCabe the carers' address. Given previous threats made by RR that he would remove the children from the foster carers, Scott McCabe contacted the police to inform them of the situation.
55. On 10 February 2009, M and D McA gave 28 days' notice of termination of the placement due to being threatened and constantly undermined by MC and RR. Threats had been made to Mr and Mrs McA that their own young daughter would be assaulted. They also felt that the foster children were not safe in the placement, now that the parents knew their address, as threats had repeatedly been made that they would come and remove the children from the placement. Mr and Mrs McA stated in their notice letter that "We also feel that for the last nine months although we have managed the placement that the extra stress created by the family has been allowed to continue and that we as a family cannot continue to live this way".
56. Mrs McA did not consider keeping any of the children in her care because, there was no reason for the children to be separated and, the reasons for terminating the placement related to the behaviour of the children's parents. Scott McCabe explained to the children that it was not their fault that they would have to change placement. He was conscious that child D constantly felt that "he's to blame for everything."

57. On 20 February 2009 at the next children's hearing, during the notice period for the McA placement, the Social Work Department advised the hearing that rehabilitation of the parents was no longer being considered. The Social Work Department recommended that the supervision requirements for the children should continue and that the children should continue to be accommodated by the local authority. A reduction in contact from twice weekly to fortnightly contact with MC and RR was sought, as well as a condition that the children should be moved to local educational establishments and a condition that child D should be permitted to visit his aunt, as MC and RR were not giving their permission for this. The children's hearing agreed that contact with MC and RR should be reduced to fortnightly and supervised. The reasons for this were based on findings of the Family Contact Service report, evidence of emotional distress to the children caused by contact and on the difficulties for the parents in managing contact. The hearing did not at this time make a condition that the children should move schools and nursery to local establishments, despite child D strongly expressing his wish to attend a local school. He also told the hearing that he wanted to go home, but only when his mum and RR were ready. Nor did the hearing make a condition that child D be permitted to have contact with his aunt.
58. Immediately after the children's hearing of 20 February 2009, MC verbally abused child D and blamed him for the decision made by the hearing. Child D's paternal uncle also shouted and swore at him, blaming him for the decision, as well as swearing at social work staff. For Scott McCabe, who was present, he had never had another experience like that, and this was an extremely distressing incident.
59. On 23 February 2009, at the next contact session, MC again repeatedly directed blame at child D for the children being accommodated, swearing at him, and saying to him repeatedly "What did you say that for? What did you tell those lies for? It's all your fault."

60. The Family Contact Service report, which the children's hearing took into account when making its decision on 20 February 2009, recommended based on its assessment of the parenting capacity of MC and RR that the children should not be returned to their care and that permanent placements should be secured for the three children. It was observed in the report that "child D, in particular, appears unhappy and upset during contact, and it would appear that contact in its current form reinforces child D's negative self-image and continues to cause him some emotional upset. Given the chaotic nature of contact and the parents' inability to meet the individual needs of each of their children, the family contact centre would recommend a reduction in contact to fortnightly in the first instance. We would also recommend that child D has contact with his parents in the absence of his sisters in order that he receives the individual attention that he needs."
61. Scott McCabe considered that the placement with Mr and Mrs McA was a positive placement for the children in which they were settled and happy and where there was a calm, relaxed atmosphere. Whilst acknowledging that the children could be challenging, it was his view that Mr and Mrs McA understood the children well and that the children responded to boundaries that were put in place for their benefit. This contrasted with contact with MC and RR. There they would be more aggressive towards each other and towards others, and were described by Scott McCabe as being "out of control". This behaviour would continue until after they arrived back at the placement and the children would struggle to behave after they returned from contact sessions.
62. When contact was reduced by the children's hearing on 20 February 2009 to fortnightly, various family members including MC and RR started attending at the children's primary school with more frequency in the morning, at break times and at lunchtimes, having unauthorized and unsupervised contact with the children. This continued until the children were given permission by a children's hearing on 28 April 2009 to move to a school and nursery local to the foster placement. The Deputy Head Teacher, Angela Guthrie, described the children as being

“emotionally unsafe” at the school, indicating that this was seriously impacting on their educational progress.

#### **Placement with Fiona and Barry Edwards**

63. Fiona and Barry Edwards were newly approved foster carers with FCAS when child D and his two half-sisters were accommodated with them. They lived approximately 20 minutes’ drive from Glasgow. Mrs Edwards, a qualified nurse with ten years of experience, stayed at home as a full time foster carer and Mr Edwards worked at Ballikinrain Residential School as a residential worker. Their 19 year old daughter lived at home, and they had three adult sons who did not live at home, but who visited and had contact with child D.
64. After being provided with social work background reports and being provided with information in relation to child D and his half-sisters by Scott McCabe, Fiona and Barry Edwards met with Mrs McA on 17 March 2009, to discuss information relating to the children, details of their day to day lives, routines, boundaries, and the impending move. Mr and Mrs Edwards considered that they had been provided with a lot of information by the Social Work Department.
65. On 20 March 2009, Eileen Leber, FCAS senior supervising social worker, visited the placement and gave the children information in relation to the change of placement. She stated that she did this because there was no one available from the local authority to do this. The children had already discovered at the previous children’s hearing that they would have to move. This placement commenced on 28 March 2009, after an overnight introductory visit with Mr and Mrs Edwards on 25 March 2009.
66. At a continued children’s hearing on 28 April 2009, the hearing continued the supervision requirements of the three children with a condition of residence with Fiona and Barry Edwards, also making conditions that the children should attend local educational establishments. The reasons given for this were that there had

been unscheduled contact with MC, who had been attending at the school to have unsupervised contact with the children. Also, the panel considered that the children needed a chance to fully settle in their placement, taking into account the length of travel to their old school and issues relating to their emotional welfare. Fiona Edwards later reported to Scott McCabe that the children “jumped for joy” when they were told that they were now allowed to attend a local school. Child D had been expressing to the Social Work Department for many months before that he had wanted to go to a local school with his local friends. The condition of fortnightly supervised contact was continued.

67. Mr and Mrs Edwards were an appropriate match for the children. Barry Edwards worked in Ballikinrain School with children exhibiting challenging behaviours. Fiona Edwards was a full time foster carer, who was described as being very warm. Stephen Lorimer, allocated local authority social worker after Scott McCabe, formed the view that Mr and Mrs Edwards were highly skilled foster carers, in particular Fiona Edwards, who exhibited a very nurturing approach to caring for the three children. While this was their first foster placement, he did not have any concerns about Mr and Mrs Edwards.
68. Scott McCabe considered that while child D did miss his previous carers, he and his half- sisters seemed “fairly settled” and seemed to enjoy the new placement. In May 2009, the three children moved to a local school and nursery, as per the condition placed by the children’s hearing on 28 April 2009 and became more settled.
69. On 18 June 2009, the children’s case was formally handed over to Stephen Lorimer from Scott McCabe. The case had to be reallocated as a result of ongoing aggression, intimidation and threats directed towards Scott McCabe and his children over a prolonged period of time. This case was not the only case in which Scott McCabe had ever been threatened by clients, but it was the only case in which he required to call the police as a result of being threatened in the course of his

work. RR was ultimately convicted of a breach of the peace on 28 July 2009 in respect of an incident in which he threatened Scott McCabe and Rikki Laird.

70. Stephen Lorimer was chosen as Scott McCabe's replacement because he was considered to be an unassuming, but reliable, competent and conscientious worker who was skilled in working with people who resisted engaging with the Social Work Department. He was also considered to be good at building relationships with young people, and it was considered important that child D be allocated a positive male role model. Kevin Brown considered that Stephen Lorimer would be able to navigate through some of the difficulties and complexities that the Social Work Department was having in terms of decision making and attempting to progress the care plan, given Mr Lorimer's history of working with permanence cases.
71. On 11 August 2009 at a contact session with MC and RR, child D was given a mobile 'phone by a member of the family. Mr and Mrs Edwards were concerned about informal contact taking place with family members, due to this present being given.
72. By 13 August 2009, the Social Work Department had been told by the foster carers that child D's bed-wetting had much reduced and that he was now wet on average once per week, whereas he had previously wet himself six to seven times per week. It was reported that he seemed reassured that when an incident did occur, he could report it to the carers and then take the bedding to the laundry basket.
73. On 27 August 2009, a LAAC Care Plan Review took place, and recommended that the children remain looked after and accommodated and in the care of Fiona and Barry Edwards, that the LAAC Mental Health Team advise the care plan group, having already offered to work directly with MC and RR in order to complete a more comprehensive mental health assessment of the children, that various health appointments be ongoing for the children, that consent for child D to attend a

school trip be sought and that MC and RR continue to work with their own professional network in order to support them in their parenting capacity for contact. The Social Work Department recommendation to the following children's hearing would be that the children should remain subject to supervision requirements with all of the existing conditions.

74. By September 2009, child D was responding well to guidance and boundaries, was attending a local sports club, had been trained as a "buddy" at school and was "on track" academically. The LAAC mental health team was working with the carers to manage the behaviour of all the children, but MC and RR would not work with the mental health team in relation to improving the quality of contact. The Social Work Department considered that the reduction in contact had resulted in positive outcomes for the children, based on views of education representatives and the foster carers, who reported fewer instances of nightmares and fewer unsettled behaviours being exhibited by the children. There were no plans to return the children to MC and RR, and Parental Responsibility Order applications were to be pursued in respect of the children. The LAAC care plan was that the children should remain accommodated, that contact with MC and RR remain fortnightly, that the children would attend their health appointments and that child D should be given permission to attend a school trip. The Social Work Department recommended that the supervision requirement be continued with existing conditions.

75. On 22 September 2009, a children's hearing was convened. The panel had not received the relevant recent papers. The hearing was continued for full reports and a Safeguarder was appointed to address issues surrounding the conflict between the parents and the Social Work Department. The presence of the children was dispensed with for the following hearing. At this hearing, child D came into the waiting room and told his foster carers that he might be "getting home today". It was unclear why he was under this impression. He sat next to MC at the hearing, but received very little attention from her. He was told at one point to leave the

hearing room in order to allow the panel to discuss matters relating to child C with Gillian Sloan, child psychotherapist, but was not happy about this and became disruptive, demanding to be allowed out of the waiting room and back into the hearing room. At the end of the hearing, MC came to the waiting room and took child S in her arms. She gave child D no attention at all, until he asked her for a hug. When handing over child S as she left, MC struck her head against a wall, in front of the children. The following day, child D became very disruptive, argumentative, moody, cheeky and attention seeking. He banged on walls and shouted that he was going to “do a child C”. He was also involved in a fight with a boy at school a couple of days later. He later apologized to his carers and said that he was upset about the hearing, his mother giving the girls more attention than him and his mother banging her head off a wall. This had not been an unusual hearing experience for child D, hence the reason why Stephen Lorimer often attempted to seek dispensation of child D’s attendance at children’s hearings.

76. On 20 November 2009, at a children’s hearing, the supervision requirement was continued without variation, the children’s hearing having considered the report of Safeguarder Jeanette Mason.
77. On 2 February 2010, it was reported to the Social Work Department by Mr and Mrs Edwards that child D had not been bed-wetting in recent times, after he had attended a clinic and had been prescribed medication. Upon arrival at the placement, child D had been wet on most days, but medication had improved the situation.
78. On 1 March 2010 at the end of a contact session between child D, his half-siblings, MC and RR, an incident ensued during which MC became distressed that the children were leaving, and both MC and RR became threatening towards social work staff. MC started crying and screaming, and then repeatedly struck her head against a railing. She then fainted and an ambulance was called. The children witnessed all of this behaviour. Magdalene Sewell, Team Leader, who was

present, was concerned about the negative emotional impact of this behavior on the children, and was also concerned that the Social Work Department, even with several members of staff present, could not keep the children safe in such a situation.

79. At contact child D appeared not to get the same attention as his half-sisters.

Children C and S would come back to the placement very “hyper” and excited, with “bag loads of toys”, while child D would come home, having been given no presents, and would be very quiet and very withdrawn. He would often say that there was no point in him attending contact because nothing happened for him. After the contact session on 1 March 2010, Mrs Edwards stated that child D was upset and felt terrible, having seen his mother striking her head on the fencing and fainting. He said that he did not understand why his mother had done this.

80. On 30 March 2010 at a children’s hearing, the supervision requirements of the children were continued with a condition of residence with Fiona and Barry Edwards, holidays with the foster family within the UK were to be permitted, and supervised contact with MC and RR was reduced to once every two months for a minimum of two hours. The children’s hearing had access to the LAAC CAHMS assessment report in relation to the impact of contact on the children, and information relating to RR attending a contact session under the influence of either drugs or alcohol on 1 February 2010, with the very difficult, chaotic and aggressive contact session that followed. They were told of MC deliberately striking her head against railings outside the social work office after a contact session on 1 March 2010 and an ambulance had to be called, child D being blamed by family members for decisions being made by previous children’s hearings, and being scapegoated for the fact that the children were in care, and child D withdrawing at contact, for example sitting behind a sofa and not interacting with the others in the room. The panel decided that contact was to be reduced as it was “enough for these fragile children to cope with”. This decision was appealed by MC and RR, who are relevant persons with a right to appeal under the Children (Scotland) Act 1995.

81. On 16 April 2010, Stephen Lorimer visited child D at the placement and told him of the children's hearing decision to reduce contact to bi-monthly. Stephen Lorimer advised child D that the reasons for the reduction in contact were that child D and his half-sisters can become anxious prior to and after contact and that there had been recent incidents in contact that were not good for him and his half-sisters to witness. While he appeared not to be strongly affected by this information, it was observed by Fiona Edwards' daughter that when leaving the kitchen area afterwards, child D had punched the banister.
82. In early May 2010, Debbie Foley (now Lucas) took over the role of supervising social worker for the Edwards from Christine Mitchell, who started maternity leave. She thereafter carried out home supervision visits on *inter alia* 17 June and 22 July 2010.
83. On 1 June 2010, child D attended a contact session with MC and RR at his twelfth birthday. They gave him a laptop with a dongle for internet access as a present. Fiona and Barry Edwards were concerned about this and discussed this matter with both Stephen Lorimer and Debbie Foley. As a result of discussions, an amendment was made to child D's Safer Caring Policy, which is a living document drafted by FCAS carers in respect of each child in placement. The document outlines the household policies in relation to issues of safety and is signed off by the carers, foster child and FCAS supervising social worker. It was decided that child D would be supervised when using the laptop and that he would not be allowed to use the laptop in his bedroom.
84. On 18 June 2010 at Glasgow Sheriff Court, the appeal against the decision of the children's hearing on 30 March 2010 was upheld and the case was remitted back to children's hearing for consideration.
85. On 20 July 2010, Fiona Edwards indicated to Stephen Lorimer that she had discovered on child D's laptop (which had been given to him by MC and RR for his

twelfth birthday) photographic images of his older half-brothers posing with knives and other weapons with a banner in the background naming the local gang to which they were affiliated. It was unknown whether child D had seen these images on the laptop. Stephen Lorimer advised Fiona Edwards to delete these images.

86. By July 2010, Stephen Lorimer, who had now been child D's allocated social worker for a year, was of the view that child D appeared to have made good relationships with Mr and Mrs Edwards and their extended family, was expressing that he was happy living there and was involved in social activities in the community. He appeared to be doing well academically in school. Child D had made some recovery with Mr and Mrs Edwards, was enjoying a stable period in his life and that he had all the opportunities required for him to grow and develop.
87. In relation to contact, Stephen Lorimer considered that at this time child D appeared to have more interest in having contact with his older half- siblings, than with MC and RR. He would on occasions be passive or indifferent when Stephen Lorimer discussed with him issues or wishes relating to contact. Stephen Lorimer considered that child D would become anxious in the lead up to contact and that his bed-wetting would then become more prominent. He considered that child D's experiences of contact were "horrendous" and that following contact, he would be more unsettled.
88. On 2 August 2010, child D was given a mobile 'phone by MC at a contact session.
89. On 3 August 2010, the remitted children's hearing took place. The children's hearing decided to continue the supervision requirement without variation. They considered information provided by the Social Work Department that since March 2010, when the decision was initially made to reduce contact to bi-monthly, the children had had more stability in their lives and had presented as more settled since then. They took into account the information provided by Fiona Edwards

that the behaviour of the children and their routine had been much more settled since contact had been reduced in March. Fiona Edwards also reported that the children's emotional security had improved dramatically since March, that the children had not asked for contact with MC and RR since March and had in fact had contact sessions in June and in July with other family members, which they had enjoyed. The panel also requested that another parenting assessment, this time for only MC, be carried out. MC at this time claimed that she was separated from RR, and that she was seeking to have the children return home to her care alone. An early review was also set.

90. On 19 August 2010, child D was difficult, argumentative and defiant and would not follow direction given by Barry Edwards. He was told that he was to go to his room for "reflection time" and that he was not permitted to take his mobile 'phone to his room with him, failing which he would not be allowed to watch television or play on his x-box for an hour. He responded by going to his bedroom and punching a brick wall in the house. He started crying and he was given an ice pack and painkillers by the carers. He could move his fingers, but when his hand was found to be swollen and painful the following morning, he was taken to hospital. He was found to have a fractured metacarpal in his hand. Plaster was applied to his hand. The day after the incident, he wrote a letter of apology to Stephen Lorimer, acknowledging that the incident was his fault and not Barry's, saying that he did not want to leave the placement or his school, and saying that he loved living with Mr and Mrs Edwards and would not repeat his actions.
91. Witnesses to the Inquiry expressed various differing views in relation to the significance of this incident. Some did not regard this as a serious. Fiona Edwards considered that this incident was out of character for child D and that he was remorseful. However, Dr John Marshall, Consultant Child Forensic and Clinical Psychologist, did not consider that this was "normal teenage behaviour". Dr Marshall considered that this was the behaviour of someone who was struggling with tolerance or frustration, struggling with boundaries, and presenting with

significant oppositional and defiant behaviours. Others, including Ms Anne Ritchie, independent social work consultant, who described the incident as a “very normal event” and Ms Kirstie MacLean, independent consultant to the Significant Case Review, did not regard it as raising serious concerns.

92. On 3 September 2010, during a visit by Stephen Lorimer to the placement, child D asked to find out more about his “real dad”. Stephen Lorimer told him that he would speak to MC about this.
93. On 12 September 2010, Fiona Edwards called social work standby service to report that child D had been threatened by a 13 year old boy with two knives while playing in the street. The incident was also reported to the police, who spoke with both child D and a neighbor who had witnessed the incident. Later the same evening, the same boy approached an adult son of Mr and Mrs Edwards, again uttering threats in relation to child D. The police were called again. As a result Mr and Mrs Edwards carried out a risk assessment, and decided to temporarily give child D a mobile ‘phone to use for his own security (as he had lost his own mobile ‘phone), and arranged to have him taken to and collected from school. FCAS was contacted as well as the Social Work Department. Stephen Lorimer agreed that child D should be taken to and from school for the rest of the week and should be kept in at night. As a result of the incident, Mrs Edwards discussed the Safer Caring Policy with child D and it was updated to include him being dropped off and collected at school, the provision of a mobile ‘phone for emergencies and the decision that he would not leave the house after school that week, although he could have a friend come around to the house to play. It was decided that the police would be contacted if the offender in question came near the house and behaved in an intimidating manner.
94. Fiona Edwards was concerned that child D did not appear to be concerned or scared by the incident, and was concerned that he might not back down from a threat like this, given his family background. She was also concerned that if his birth family

heard of the incident, they might try to take matters into their own hands, or encourage him to do so.

95. On 13 September 2010, child D was found by Barry Edwards to be accessing a video of his older brothers brandishing knives and drinking Buckfast wine on YouTube. Mr Edwards discussed with child D his responsibilities when using the laptop.
96. On 15 September 2010, child D met with Debbie Foley, FCAS Supervising Social Worker, who had a discussion with him in relation to the incident on 12 September, how to keep himself safe and his responsibilities in relation to how he should behave. Mr and Mrs Edwards and Debbie Foley discussed the reasons why they were concerned for his safety, and the reasons why he should not engage in any confrontation with the other young person. The newly updated Safe Caring Policy was written and signed by child D, after being discussed with him.
97. On 17 September 2010, Fiona Edwards called social work standby service again to report that at around 7pm child C had been approached by the same boy who had previously approached and threatened child D. The boy had told her that he was going to kill child D. She reported this to Mr and Mrs Edwards, who contacted child D and told him to come directly home. The incident was also reported to the police.
98. Child D's response to being threatened again by the same boy was that perhaps the only way to deal with the matter would be to deal with it himself. When asked by Fiona Edwards what he meant by that, he said "If I fight him and beat him, he will back off". Mr and Mrs Edwards were concerned about this and explained to him that this attitude would not help, and would result in putting himself in danger or getting himself into trouble. Mrs Edwards was concerned that this situation was undermining the placement for a number of reasons. Firstly, Mrs Edwards had concerns about now allowing child D's sisters outside to play as they did not have the same understanding as him in relation to safer care policy procedures.

Secondly, even with the safer care policy in place for child D, they felt uneasy about him being out of the house, although they recognized that to keep him in the house all the time would have made the house “like a prison for him”. Thirdly, Mr and Mrs Edwards were concerned that he may take matters into his own hands and make matters worse for himself. Fourthly, they were concerned that if the boy who threatened him were to be charged, a counter allegation may be made against child D. Fifthly, even if the boy who had threatened child D were to be charged, a referral would be made to the children’s hearing and this would take some time to deal with. The boy would still be out in the community and child D and his sisters may still have been at risk of harm, or at least intimidation. They were also concerned about the possible repercussions for the other boy if child D’s parents found out about the threat.

99. Stephen Lorimer considered that child D had appeared to be unconcerned by the threats made towards him, and did not view these incidents as a significant matter in terms of his placement, security or wellbeing.
100. At the end of September 2010, Debbie Foley, FCAS supervising social worker, went on sick leave. She did not work with Mr and Mrs Edwards again after that.
101. The period that child D spent living with Mr and Mrs Edwards was a relatively stable period in which he appeared to enjoy the nurturing that he received. He made good relationships with Mr and Mrs Edwards, was doing well at school, was participating in social activities in the community and appeared to be making some recovery. He went on to grow and develop, his bed-wetting had reduced significantly, and at one point during the placement, he stopped bed-wetting altogether.
102. Stephen Lorimer thought that Fiona Edwards appeared happy and might have been willing to care for the children in the longer term, although not necessarily permanently. He had no specific conversations with Mrs Edwards regarding the

possibility of her becoming a permanent carer for these children. Mr and Mrs Edwards, did, however, remind Magdalene Sewell, team leader, at one point in the placement that this was not a permanent placement, and it was never their intention to become permanent foster carers for any children.

103. Fiona and Barry Edwards remained concerned about the input of the birth family, as they were aware of the reasons why the previous placement had broken down, and were concerned that the parents would try to ascertain where the children were living and remove them.

104. At a meeting on 1 November 2010, Mr and Mrs Edwards gave written notice to FCAS of their intention to terminate the placement. The period of notice was 28 days. Mrs Edwards handed the notice letter to Clare Flannery, Team Manager, and Linda Nicholson, the newly allocated supervising social worker whom she met for the first time during that meeting. The reason in their written notice letter was primarily that Mrs Edwards' father was very ill and that she had decided to be his full time carer. She did not feel that she could meet her obligations as a foster carer and also care for her father at the same time, especially given the fact that each of the children required a lot of attention and care.

105. The Edwards found looking after the children exhausting and they were feeling very tired. Mrs Edwards was struggling to differentiate between the behaviours that the girls displayed and the children themselves, and due to difficulties between the local authority and the children's parents, no long term plans had been made for the children. This had compounded difficulties with the children as the children were aware of this. The children struggled when the Edwards gave their time and attention to their grandchildren. Mrs Edwards believed that child C's baseline was chaos and that she would manipulate situations and circumstances in order to bring chaos to her. She told the FCAS social workers that she considered that the sibling group would benefit from being separated, and that the girls would benefit from having separate bedrooms.

106. Stephen Lorimer was shocked and completely surprised when Mr and Mrs Edwards gave notice on the placement as they had never at any point indicated an intention to give notice. His initial reaction was that this would be a terrible outcome for child D and his sisters, that they again required to move placement.
107. Prior to termination of the placement, Magdalene Sewell, Practice Team Leader and Stephen Lorimer's line manager, spoke to Fiona Edwards about the possibility of continuing to care for child D alone while the girls moved to another placement. Mrs Edwards declined to continue to care for him for the same reasons that she had considered it necessary to terminate the placement in the first place.
108. On 15 November 2010 at a home visit, child D told Stephen Lorimer that he wanted to know more about his birth father. Stephen Lorimer informed him of his birth father's name, JO, and told him that his mother would give him more information in a one to one contact the following week. While MC had indicated at a meeting with Stephen Lorimer on 20 October 2010 that JO had been deceased for some years, it is unclear when exactly child D was told this, and by whom.
109. Linda Nicholson (who was a newly appointed supervising social worker at FCAS, and had no experience of working with foster carers nor any experience of dealing with the matching process between foster carers and children) was told on 15 November 2010 during a telephone call with Stephen Lorimer, that a placement had not yet been found for child D, and asked informally whether FCAS had any placements available. She informed Fiona Sym, her Team Leader, of the request.
110. On 16 November 2010, a children's hearing took place. A Safeguarder was appointed at this hearing on the basis that there was conflict between MC and RR on one side and Stephen Lorimer on the other.

111. GCC's Placement Services would not as a matter of practice request that more than one independent fostering agency at a time seek a placement for the same child. In this case, child D was already residing with FCAS carers and FCAS was asked to source another placement for him. Only if FCAS had been unable to source such a placement would another independent fostering agency have been approached to try to find a suitable placement.

112. On 18 November 2010, during the notice period, Stephen Lorimer met with Gillian Sloan, Child Psychotherapist, of the LAAC Mental Health Team. It was discussed that the change of placement was unplanned and that this would be a difficult move for the children. There were concerns that this move may have a detrimental effect on the children, given that they appeared to have formed important attachments to their carers. The children did not know at the time of this meeting that they would have to change placement. Those present discussed the fact that the children had been with their present carers for 20 months and had made significant progress during that time. They were going to have to change school, and they may grieve the losses that this move would involve. It was agreed that support would have to be increased for the children and their new carers, and if the decision was to be that the children would have to be separated due to a lack of carers available to foster the three children together, there would have to be regular contact between the siblings. Ongoing concerns in relation to contact were also discussed, including issues such as MC banging her head against railings in the presence of the children and child C returning to placement from contact asking if her hair was ugly, as MC had told her this during contact. Child D was still being isolated at contact and child C was still struggling at the end of contact sessions. Concerns were also discussed in relation to MC and RR threatening to video record the contact sessions. Gillian Sloan envisaged having ongoing involvement with the children as they moved placement. There was a plan to work with the new carers, although no specific plan to have individual input with the children. MC and RR were offered support in the form of advice and guidance, and declined. There were no imminent plans for the Team to see the children again at this point, but

rather the intention was for the Team to continue to be involved on a consultative basis.

113. On 18 November 2010, Fiona Edwards called Linda Nicholson to ask her if she could tell the children about the change of placement. Linda Nicholson advised that this should probably be done by Stephen Lorimer and that she should wait until he was available.
114. By 22 November 2010, a placement still had not been sourced for child D. His half-sisters were to be placed with GCC foster carers. In a telephone discussion with Fiona Edwards, Gillian Sloan suggested waiting until just a couple of days before the change of placement before informing the children of the move. Gillian Sloan suggested that Mr and Mrs Edwards should then visit the children in their new placement, to let the children see that they had not disappeared out of their lives. During this telephone discussion, Mrs Edwards indicated that if child D were to be placed separately from his half-sisters it would be good for him to have the attention of a pair of carers to himself, but that contact with his half-sisters would need to be arranged regularly. She felt that it was important for child D to feel part of a family, as he could so easily feel left out, or pushed out. Mrs Edwards and the GCC social workers did not wish to tell the children about the placement ending until they were in a position to tell the children where they would be going. Ms Sloan agreed with that.
115. On 25 November 2010, Mrs Edwards contacted Linda Nicholson to tell her that she was happy to inform the children of their move, and in late November 2010, during a telephone call with Stephen Lorimer, she indicated that she wanted to tell the children about the change of placement and wanted to do the preparatory visit with the children to the new carers. Normally, this visit would be carried out by the local authority social worker, as would breaking the news of the change of placement to an accommodated child. Stephen Lorimer discussed this with Magdalene Sewell, his line manager, and it was agreed that this could be the

process for introducing the children to the new carers on this occasion. Mrs Edwards said that she was more than willing to facilitate the move to the new carer, as she felt that if a social worker had come into their house and taken them and their things, it would have brought back memories of the children being taken away from their own home and from their parents.

116. When Fiona Edwards told the three children that the placement was going to end and that child D was going to be separated from the girls, the girls were more upset about the prospect of the siblings being separated than he was. He was more upset about the prospect of leaving the placement than the prospect of being separated from his half-sisters, although he reported to Dr John Marshall, after the death of Mrs McKenzie, that he was “gutted” about having to leave the placement with Mr and Mrs Edwards.

117. It was not unusual for placements to be found late in a notice period. It was rare to be offered a choice of more than one foster placement for a child.

118. There was little opportunity to plan and prepare for the change, as the placements were not confirmed until only a few days before the notice period ended. Stephen Lorimer had no choice in relation to which placements the children were moved to and was not involved in planning, preparation or introduction of the children to their new placements. He was not involved in the matching process. Social workers would normally read the carer profiles and contribute towards the matching process. In this case, there were no alternative options for the children, as only one placement in respect of each child could be sourced.

119. Prior to child D being placed with Dawn and Bryan McKenzie, Stephen Lorimer did not see any carer profiles or other information in relation to the new carers, nor did he meet them. There had been ongoing dialogue between Stephen Lorimer and Placement Services in which Mr Lorimer had indicated that if it was necessary to separate the siblings, child D should be placed in a singleton placement, preferably

with a young, active couple. There had not, however, been any dialogue between FCAS and Stephen Lorimer prior to the decision being made that child D would be residing with Mr and Mrs McKenzie. He did not have any input into this decision and it was presented to him as a “done deal”. This was not common practice, and he did not consider this to be good practice in terms of matching.

120. However, had he been given the opportunity to visit Dawn and Bryan McKenzie prior to the placement move, he would have seen the benefits of this placement for child D, given that Mr and Mrs McKenzie were a young, enthusiastic couple who were keen to foster care. He would have viewed this as an “ideal placement”, had he been given the opportunity to assess the placement in advance.

#### **Background Information in relation to Dawn and Bryan McKenzie**

121. Dawn McKenzie (nee Byrne) was born on 26 May 1977 in England. She and her family moved to the West of Scotland from England when she was a young child. Dawn McKenzie had a mother, Ray Byrne, a brother and a sister. Her sister had two children, one of whom, Jordan, had been raised by his grandmother, Ray Byrne.
122. Bryan Thomas McKenzie was born on 23 August 1974.
123. Dawn and Bryan McKenzie met in 1997. They married on 19 August 2000. After marrying, Dawn and Bryan McKenzie lived in Hamilton together. They moved into the placement address in Hamilton, in March 2003. They had no children.
124. Dawn McKenzie was qualified as a nursery nurse, and prior to her death had been the deputy manager of a private day nursery in East Kilbride. She had ten years of experience as an early years worker at the point when she applied to be a foster carer. Bryan McKenzie is a joiner. He described Dawn as a person who enjoyed cooking, music and spending time with her family, and as a sweet, kind, very caring, strong, determined, hardworking person who was very much family

orientated and who had an affinity with children. Ray Byrne, Dawn's mother, described her as very loving, very family orientated, very honest, very strict but fair, as a person who knew her own mind, whose family meant everything to her and a person "who was there for everybody".

125. Dawn McKenzie had a close relationship with her mother, Ray Byrne, and she and Bryan spent a lot of time with Dawn's nephew Jordan, who was raised by Ray Byrne. Until he was around 10 years old, Jordan regularly stayed overnight at weekends with Dawn and Bryan thereafter spending weekends with his friends instead.

126. Around late 2009 or early 2010, Bryan McKenzie became aware that Dawn was considering becoming a foster carer. He was supportive of Dawn's desire to pursue this. They did not know any other foster carers at this time. Dawn applied to an independent fostering agency, FCAS, after seeing an advertisement in a newspaper. She made an initial enquiry to the agency on 11 January 2010 after doing some research into them. They did not apply to any other agencies, although she may have done some research into others. At the initial stages Bryan McKenzie did not perceive any particular challenges for the couple.

127. After the initial enquiry, Mr and Mrs McKenzie were visited at home by a representative from FCAS, who obtained further information in relation to the couple. In terms of their motivation to foster, the couple had been thinking about fostering for a long time, and wanted to make a difference to a young person's life. Dawn was willing to give up her full time employment, and her employer was supportive and was willing to give her time to go on training. Mr and Mrs McKenzie indicated that they felt that they had transferable skills, and necessary experience to manage any challenges and were willing to do the necessary training. They felt that they had a good understanding of the factors that led to children being separated from their birth parents and understood that there would be challenges. It was recorded that they were open and willing to consider children

aged 0 to 16 years. FCAS considered that the motivation of Mr and Mrs McKenzie felt genuine and recommended that they proceed to Skills to Foster training in February 2010.

### **Training and Assessment of Dawn and Bryan McKenzie**

128. Both Dawn and Bryan McKenzie attended the “Skills to Foster” course from 24 to 26 February 2010, prior to being approved as foster carers. This training was delivered by Katya Conway, supervising social worker for FCAS. Both Dawn and Bryan McKenzie presented well at the training, and Dawn in particular had a lot of transferable skills and knowledge. After being recommended for full assessment by Katya Conway, Mr and Mrs McKenzie completed a formal application form.

129. The full assessment, using a Form F, was carried out by Valerie Lawrence, an independent assessor for FCAS. This was the second assessment that Ms Lawrence carried out for FCAS. FCAS employ independent assessors to carry out the Form F assessment, as opposed to using FCAS employed social workers.

130. The Form F assessment is the assessment used by most independent fostering agencies and local authorities for assessing new foster carers. It is a competency based framework. The assessment was designed by the British Association for Adoption and Fostering (hereinafter referred to as “BAAF”).

131. Prior to commencing the assessment, the assessor is provided with the potential foster carers’ application form and the feedback from the Skills to Foster course. Various checks are done, such as police checks, health checks, Disclosure Scotland checks, the results of which are passed to the assessor.

132. The assessment consists of a minimum of 12 visits to the home of the prospective foster carers, including meeting with each partner separately. The visits are usually weekly or fortnightly, and the timescale for completion of the assessment is approximately 6 months. Written references from employers, close family and

friends are sought. Close family and friends who are likely to be involved in the life of any foster child are also interviewed. A full GP assessment is done for each prospective foster carer and considered by the fostering agency's medical advisor. A health and safety check involving assessment of the applicant's home, garden, pets and vehicles is done.

133. Prospective foster carers are required to complete a portfolio in which they keep evidence of their competencies. The competencies can be evidenced through personal statement by the carers, case studies, work produced as a result of exercises assigned by the assessor, reading and feedback to show understanding, and statements from family members or other employers in addition to the official referees. This evidence of the competencies is also used to inform decisions in relation to the number of children, age range of children and categories of children for which the prospective carers can be approved.
134. The assessment process for Mr and Mrs McKenzie commenced on 14 May 2010. The process consisted of various practical and contemplative exercises, extensive background checks on the couple and a health and safety assessment in relation to the family home. Valerie Lawrence completed the Form F assessment for Mr and Mrs McKenzie on 6 October 2010, after making 12 home visits. She considered that no significant issues arose in relation to the assessment of Mr and Mrs McKenzie, although one issue was considered and resolved after investigation. The health checks in relation to Mr and Mrs McKenzie confirmed that there were no health issues in relation to either of them.
135. Valerie Lawrence considered that the matching process should not be based simply on the applicant's wishes, although the applicant's views of what they could deal with in terms of a placement and the reasons for that would be taken into consideration. The assessor's assessment of the capabilities of the applicant and the categories of child that the applicant could care for would also factor into the overall conclusions. It was considered Mr and Mrs McKenzie would be capable of

caring for a child who may have been physically abused, a child who had been neglected, a child who had been emotionally abused and a child who would be unlikely to make relationships easily. They would be able to care for a child who may display overt behavioural difficulties “with limitations”. While Ms Lawrence considered that while Mr and Mrs McKenzie may struggle at this stage with children with defined behavioural difficulties, such as ADHD, she was clear that they would be able to provide appropriate guidance and support to a looked after child whose social, emotional and behavioural development had been affected by permissive or neglectful parenting. She assessed these matters through a question and answer process, specific exercises, cases studies, tasks, reading and questionnaires to build up a picture of Mr and Mrs McKenzies’ overall understanding, knowledge, and attitudes to the different experiences that looked after children may have had.

136. It was recorded on the Form F that “The couple feel the most appropriate age group is 1 to 8 years, but they are open to offering a placement to children 0 to 16 years”. The couple had no preference in relation to the gender of child. Ms Lawrence considered that clearly there was a preference for children between 1 and 8 years in terms of skill base and experience. Ms Lawrence stated that the terms “preference” related to the preference of both the prospective carers and the assessor”. It was further recorded on the Form F that “As they’re hoping to have children in a few years’ time they’ve considered this eventuality in the context of fostering, and feel that short term placements would be most appropriate.” Ms Lawrence considered that Mr and Mrs McKenzie were committed to providing a high level of practical and emotional support to a child or young person having contact with parents and family.

137. Valerie Lawrence assessed that the evidence from the standards within their home and their personal presentation skills and values was that any child placed with them would receive a high standard of day to day physical and emotional care, food, clothing and housing, that their health care and educational opportunities

would be facilitated, and that their changing needs over time would be met such that the growth of self-care skills, responsibility and independence would be encouraged appropriately. Mrs McKenzie was a highly empathetic person with the emotional warmth and the ability to engender a feeling of security in people, and Mr McKenzie had shown that he was a warm caring person who would ensure that a child placed in their care could expect to experience a secure base. Ms Lawrence considered that a child who had experienced emotional or physical abuse could benefit from their approach to care giving. Mr and Mrs McKenzie recognized that it would be central to their role to teach positive values to the children that they foster and that she felt that they could be able to do this with skill.

138. Ms Lawrence assessed that Dawn and Bryan McKenzie's level of experience of disciplining an older child was limited. Mrs McKenzie had however undertaken specific training in relation to handling children's behaviour, and she had experience of providing childcare to children and young people, and younger children in particular, with challenging conduct, and she had a great deal of experience in caring and supporting children and young people, particularly pre-school children. Over the 13 years of their relationship they had both cared for the children of their family and friends on a regular basis and, in particular, had looked after their nephew, then aged 14, every weekend throughout his childhood.

139. Ms Lawrence considered that Mrs McKenzie had demonstrated a good level of understanding of issues of attachment, separation and loss, and that Mr McKenzie had progressed his learning in this respect. Mr and Mrs McKenzie had a good basic knowledge of what might be required to support a young person in their sexual development and education and considered that they would seek advice and guidance in relation to supporting a young person who was gay. She also considered that they had a good basic knowledge of issues around alcohol use, drug use and smoking and would also seek further advice and guidance if required.

140. In terms of identified gaps, it was recognized that Mr and Mrs McKenzie had no experience of full-time parenting or caring for a child, and that Mr McKenzie's childcare experience was limited.

141. Ms Lawrence considered that it would be important for Mr and Mrs McKenzie to receive good support from their supervising social worker at FCAS in general, and important that they should be able to access further learning and development opportunities. These training needs would be similar to those of most new carers. Ms Lawrence assessed that neither Mr nor Mrs McKenzie had the knowledge, skills and experience at this stage to deal with very challenging behaviour, and that they would benefit from having further learning opportunities in this respect, both self-directed and provided by FCAS or others. At the Skills to Foster training, Mr and Mrs McKenzie had identified themselves that they would require further advice and guidance in relation to dealing with children and young people who self-harm, and children and young people who are quiet and withdrawn.

142. Ms Lawrence stated in the Form F that "a full discussion with Dawn and Bryan about a child's particular needs before a child is placed with them will be crucial, particularly in the first year of fostering." She considered that such a discussion would take place with the allocated supervising social worker, based on information given by the placing local authority.

143. The Action Plan drafted by Ms Lawrence stated that there should be an early review of the first placement, and that the FCAS supervising social worker should carry out direct observations within the first placement. There should be continued learning through individual study and FCAS provision of specific information or training. The purpose of the proposed early review was to ensure that the carers were developing their skills and confidence and identifying early whether there were any gaps in their learning and providing ongoing support. She also stated that a high level of support should be provided by the supervising social worker

and that there should be opportunities for Mr and Mrs McKenzie to meet and to be supported by other foster carers. Ms Lawrence stated that some carers come to fostering with a great deal more experience than did Mr and Mrs McKenzie, and while Mr and Mrs McKenzie had the potential to be excellent foster carers, there were limitations to their experience.

144. Her view and expectation was that for first time carers, the placement should be planned, because they have never fostered before, and to enable the carer to have the best possible chance of putting into practice what they have learned in terms of the assessment and bringing their skills to bear.

145. Ms Lawrence stated in the Form F that she considered that it would be important that Mr and Mrs McKenzie be matched with a child or young person in accordance with the matching considerations outlined, in order to minimize the risk of avoidable difficulties occurring. She also considered that “as new carers it would be crucial that they receive a high level of support from FCAS and the other services involved in team parenting a child, to minimize the risk of placement difficulties” and that “it would be crucial that before the first placement Dawn and Bryan receive further input in relation to local authority and legal LAAC procedures and practices that they would be working with, in order to minimize the difficulties which could arise due to their lack of experience in this respect” .

146. She recommended that Mr and Mrs McKenzie be approved as temporary and respite carers for one child of either sex, or two same sex siblings, 0 to 16 years. The recommendation further stated that there was a preference for “0 to 5 years”, but this was a typographic error and should read “1 to 8 years”. That preference (for 1 to 8 years) was in recognition that Mr and Mrs McKenzie would prefer not to care for newborn babies and that, in terms of their skill base, extending the range to the lower end of primary school age would give them the potential to extend their existing skill base of 0 to 5 years to slightly older children. The preference was based on both the expressed views of Mr and Mrs McKenzie, and her views on

their capacity. Potential carers and their assessor come to an agreement about the appropriate preference which is reflected in Form F.

147. Carole McGinlay, FCAS supervising social worker who was to be allocated to Mr and Mrs McKenzie, met with them on 15 October 2010 for a pre-panel visit. Ms Lawrence should as a matter of normal practice have attended this meeting, but was unable to do so. During that visit, it was discussed that Ms Lawrence had recommended that the couple be approved as temporary carers for one child or two siblings, 0 to 16 years, with a preference for 1 to 8 year olds. Ms McGinlay discussed with Mr and Mrs McKenzie the possibility of them doing some respite care first, given their lack of experience of caring for children full time. Mr and Mrs McKenzie agreed with this proposal. Ms McGinlay noted this in her report to the Fostering Panel.

148. The Fostering Panel, on 21 October 2010, was attended by the depute chairperson Anwari Din, a service manager, a panel administrator, two independent panel members, a FCAS panel member, a FCAS observer, the assessor Valerie Lawrence, Dawn McKenzie and Bryan McKenzie. Carole McGinlay, the allocated supervising social worker for Mr and Mrs McKenzie should, as a matter of practice, have been in attendance, but did not attend. It was explained that the two-fold purpose of the Panel was to ensure that firstly, the assessment met FCAS's requirements and standards, and, secondly, to address any issues that had arisen during the assessment process which would be relevant in respect of the fostering task. The Panel considered Form F, a medical advice report and the pre-panel visit report.

149. Panel members at the Fostering Panel wanted clarification in relation to the couple's age range, as the Form F had stated that the age range was 0 to 16 with a preference for 0 to 5 years, and the pre-panel visit paperwork stated that the preference was for 1 to 8 years. The couple clarified at Panel that they did not want to limit their age range and that they were willing to take any age range but had a preference for 1 to 8 years. The Fostering Panel recommended that Mr and Mrs McKenzie

undertake a respite placement before their first substantive fostering placement. Valerie Lawrence stated that it is a relatively common practice for new carers to take a respite placement at the beginning of their career, as it can be very helpful to carers, as they are short term limited placements that provide a snapshot of the overall caring experience. The Panel asked Mr McKenzie if he had felt pressurised into fostering, given that it had been Mrs McKenzie's idea to foster. He confirmed that this was not the case and that he would not have entered into the process half-heartedly.

150. Mrs McKenzie had a preference for fostering children who were older than pre-school age, as she had spent her career looking after pre-school children and wanted to expand her knowledge and "try something else". Mr McKenzie had no difficulty with being approved for the care of 0 to 16 year olds and had been willing to consider and potentially accept a placement of a child within that age bracket. He accepted that he had limited experience of dealing with adolescent children and that he and Mrs McKenzie would have required more training and support in relation to caring for an older child. It was his understanding that the couple would be offered respite placements initially. The recommendation of the Fostering Panel had stated that "Panel members suggested to the couple that it could be helpful to undertake some respite." This was a suggestion, not a mandatory requirement.

151. Mrs McKenzie had an arrangement with her employer whereby she could give short notice to them when a placement became available, and she was welcome to return to work if she had a period of availability in between placements.

152. Dawn and Bryan McKenzie were recommended to the agency decision maker by the Fostering Panel as short term and respite foster carers for one child or two siblings, within the age range of 0 to 16 years, with a preference for 1 to 8 years, on 28 October 2010. The agency decision maker made no requirement in relation to Mr

and Mrs McKenzie taking a respite placement before a substantive fostering placement, nor did such a suggestion appear in their carer profile.

153. The fostering panel members receive no feedback in relation to their recommendations for prospective foster carers.

**Matching of Child D with Mr & Mrs McKenzie and handover from Mr & Mrs Edwards to Mr & Mrs McKenzie**

154. FCAS had an obligation to move child D from the placement with Fiona and Barry Edwards, once the 28 day notice period expired. They had no contractual obligation to offer child D a placement after that placement was terminated. The legal responsibility for appraising the suitability of the placements lay with GCC. As they had no placements which would meet child D's needs, they therefore sought another purchased placement for child D from FCAS.
155. As of 15 November 2010 a placement had not yet been found for child D. A first informal inquiry was made by Stephen Lorimer to Linda Nicholson who informed Fiona Sym, her Team Manager, of the request. The exact time when Fiona Sym was informed of the request has not been established definitively, but it was probably the same day that Linda Nicholson discussed the matter with Stephen Lorimer, or the following day. Fiona Sym formally started in her new post as Team Manager for FCAS in Hamilton on 15 November 2010. Apart from the conversation between Mr Lorimer and Ms Nicholson, there was thereafter liaison between FCAS's and GCC's placement teams.
156. Mid-November 2010 was a time of staff transition within FCAS. Fiona Sym had just started in post as Team Manager at the Hamilton office. Clare Flannery, whose post she was moving into, was still carrying a caseload within the Hamilton office for a short period before moving onto her next post, as a result of staffing shortages in the Hamilton office at that time. Eileen Leber, senior supervising social worker in the Hamilton office, was moving to a role within the Head Office as Quality

Assurance and Service Improvement Manager. Ms Leber was allocated as the supervising social worker for Mr and Mrs McKenzie, but this was an interim arrangement, pending her move to Head Office. She had not been involved during the approval process of Mr and Mrs McKenzie, and had no previous knowledge of the couple. Carole McGinlay was due to move into Eileen Leber's role as a supervising social worker in the Hamilton team, but was at that time off work as a result of sickness. Debbie Foley, senior supervising social worker, who had supervised the last four months of child D's placement with Mr and Mrs Edwards, was still off work due to sickness at this point and Christine Mitchell, who had supervised the majority of child D's placement with Mr and Mrs Edwards, was on maternity leave.

157. On 18 November 2010, Linda Nicholson completed a Referral Form Placement Move form for child D with some assistance from Eileen Leber, as she was not yet familiar with FCAS procedures. Eileen Leber knew child D, as she had been the senior supervising social worker for Mr and Mrs McA, and she was an experienced staff member in FCAS. Ms Nicholson stated in the form that the preferred location for child D would be Cumbernauld, and that child D would benefit from being placed separately from his sisters, as the girls required specific attention for their needs. A placement had already been found for his siblings with GCC foster carers. The form further stated that "Since being accommodated, child D has not shown any particular behavioural issues and, in fact, has responded well to clear and consistent boundaries which he has said make him feel safe". Under the section of the form in relation to known behaviours and potential risks, the only point highlighted was that he was bed-wetting and that this was controlled through medication. He was not considered to be a risk to children, adults or animals and was described in the form as being "an engaging child who responds well to clear and consistent boundaries, encouragement." The form also stated that "child D is really settled in the area and his carers inform that he is a lovely boy who has made immense progress since living with them."

158. A search within FCAS's Stepps team was done for a placement for child D within his present area, as child D was currently attending school there and was involved in clubs and groups within the area. They reported that there were no suitable placements available within approximately two days of the search being commenced.

159. Thereafter, the Hamilton team was approached to find a placement for child D.

Fiona Sym had a discussion with Clare Flannery and Eileen Leber on 23 November 2010 in relation to the available options and Mr and Mrs McKenzie were first considered at this point. There were no other options identified at this point because FCAS was looking for a singleton placement. Fiona Sym had no previous knowledge of Mr and Mrs McKenzie. At this time, Carole McGinlay, supervising social worker for Mr and Mrs McKenzie, was on sick leave. Christine Mitchell, who had been the supervising social worker for Mr and Mrs Edwards for the majority of their time with the children, was on maternity leave, and her replacement Debbie Foley was also on sick leave at this time. Eileen Leber's knowledge of child D dated back to her time as the senior supervising social worker for Mr and Mrs McA.

160. By the time Dawn and Bryan McKenzie were identified as a potential placement for child D by FCAS, it was day 23 of a 28 day notice period.

161. When considering whether child D could be matched to Mr and Mrs McKenzie, FCAS staff had access to the Form F for Mr and Mrs McKenzie. Fiona Sym formed the view from the Form F that they were a strong couple, and that Mrs McKenzie obviously had experience of child care through her work experience as a nursery nurse. She considered that that Mr and Mrs McKenzie had quite a high level of involvement in looking after and caring for their nephew Jordan, who was at this time around 14 years old. Ms Sym considered that they were a very warm, nurturing couple, that Mr McKenzie would be a good, positive adult role model for child D and that the couple would be able to give him the one to one attention that

the social workers considered he needed. Ms Sym considered it important that there should be no other children in the placement and that the couple would be active. She considered that Mr and Mrs McKenzie had a child centered lifestyle in terms of involvement with extended family, and particularly with their nephew, and that they were a couple who would be able to give child D a very nurturing experience of being part of a family.

162. Other information in relation to matching came from Eileen Leber, who had been the supervising social worker when child D was in placement with Mr and Mrs McA, and Linda Nicholson, who was allocated to and first met Mr and Mrs Edwards on the day that they handed in their notice in respect of child D's placement. Ms Sym considered that child D needed one to one attention, the nurturing experience of being part of a family, and carers who could support an active lifestyle for a boy of that age. She was not aware of any information in relation to him that gave rise for concern, and understood that while the stated preference for Mr and Mrs McKenzie was for younger children, Mr and Mrs McKenzie did not want to be restricted and would be open to consider caring for an older child.
163. Eileen Leber attempted to contact Stephen Lorimer during this process to obtain up to date information in relation to child D and information in relation to the current contact arrangements, but was unable to do so.
164. Fiona Sym stated that in relation to consideration of the capabilities and experience of Mr and Mrs McKenzie to care for an older child, she took into consideration their openness to looking after a child of an older age, and the fact that their experience of living with a child related to their nephew Jordan. Ms Sym understood that Jordan was not a child who exhibited any particular emotional or behavioural difficulties and that Mr and Mrs McKenzie did not have any children of their own. Ultimately, the decision in relation to suitability of a proposed

placement lay with a manager, in practice usually a Team Manager, in consultation with the relevant supervising social workers.

165. The local authority was informed that a potential placement was identified and that the potential carers would be approached.

166. Mr and Mrs McKenzie were contacted by Eileen Leber and Linda Nicholson, who met with them on the evening of 25 November 2010, to discuss the possibility of child D being placed with them. Eileen Leber, during the meeting, in trying to get Mr and Mrs McKenzie to understand a picture of chronic neglect that the children had lived in, spent a considerable amount of time talking about child D's background and history and the reason why he had been brought into care. She described difficulties that had been caused to Mr and Mrs McA by child D's birth family, the behaviour of the parents, the undermining of the placement and the fact that the parents had become aware of the carers' address and were threatening to come there. She described difficulties around contact, the behaviour of parents towards social workers and the fact that workers had been changed because of this, and also described how the situation had changed, and the parents were now more accepting of the fact that the children were not going to be returned home, although they were not happy about this. She did not bring any paperwork to the meeting. All information given to Mr and Mrs McKenzie was imparted verbally. The meeting lasted approximately 90 minutes. The notes kept were brief and not detailed.

167. Mr McKenzie recollects being told at that the meeting that the reason why child D's placement had broken down was because the foster carer's father had become ill, that his sisters were going to a separate placement, that child D had been in two previous placements with his sisters, that he had a problem with his hip, that he was a "nice boy" who wanted to join the army, that his mother was a vulnerable woman and that the Social Work Department had been involved with his family for many years. Mr McKenzie was not informed at this meeting about the bed-

wetting issue, but was first informed after the placement had been accepted, when he first met Mrs Edwards at child D's introductory meeting within a couple of days of accepting the placement. No pressure was put on Mr and Mrs McKenzie to accept the placement by FCAS, and they were urged to take time to consider it overnight.

168. After the meeting Eileen Leber considered that she now had sufficient information to allow her to make an informed decision in relation to the matching of child D with Mr and Mrs McKenzie.

169. On 26 November 2010, Dawn McKenzie contacted Eileen Leber to confirm that they would accept the placement. Ms Leber informed Fiona Sym, who passed this information to FCAS Placements Team, which in turn notified GCC of the placement availability.

170. Mr and Mrs McKenzie had been told anecdotally when speaking to other carers that if they did not take a placement when offered, they "would go to the bottom of the list". Mr McKenzie stated in evidence that "we were going to do it anyway, but we did feel that we didnae want not to take it because we didn't want to ...go to the bottom of the pile".

171. While at the time when they accepted the placement, Mr and Mrs McKenzie felt that they had enough information about child D to allow them to accept the placement, Mr McKenzie subsequently felt differently. With more information, he would still have taken the placement, but would have been more cautious.

172. The placement with Mr and Mrs McKenzie was agreed three days before the end of the notice period, with child D and his half-sisters being told on 26 November 2010 by Mr and Mrs Edwards that they would be moving placement on 29 November 2010.

173. On 26 November 2010, Fiona Sym telephoned Magdalene Sewell, local authority team leader, and Ms Sewell agreed to visit Mr and Mrs Edwards after 5pm that day and be with them as Mr and Mrs Edwards broke the news to the children. While the arrangement had initially been made that Mr and Mrs Edwards would tell the children the news without social work input, Ms Sym considered that the Social Work Department should have a role in telling the children about the placement move, and should be supporting the carers in doing that, or indeed telling the children themselves. Ms Sym also considered that to give the children continuity, social work staff should be present to support the children during this time. Ms Sewell did not attend or participate in telling the children about the change of placement. The reason for this is unknown. Ms Sewell had no recollection this arrangement made with Ms Sym.

174. Mrs Edwards was told that child D's new placement was a singleton placement and that the carers were first time foster carers. He was taken by Mr and Mrs Edwards to the new placement for an introductory visit on the weekend of 27-28 November 2010. The visit lasted between 45 minutes and an hour.

175. At the introductory visit, Fiona Edwards gave Mr and Mrs McKenzie a booklet entitled "Moving on: Information for New Carers", which contained information that she had compiled about child D's daily routine, activities, general behaviour, social skills, issues relating to boundaries, hygiene, bed-wetting, eating issues and background. Fiona Edwards also included a copy of their own up to date Safer Caring Policy for him with the booklet.

176. On 29 November 2010, child D moved into the foster placement with Dawn and Bryan McKenzie. Fiona Edwards alone transported him to the new placement.

177. When Valerie Lawrence, FCAS assessor discovered after Mrs McKenzie's death that Mr and Mrs McKenzie had been allocated a placement of a 12 year old boy, she was surprised, given that Mrs McKenzie's skill base was with small children, and

while she had experience of caring for her nephew Jordan, this was a family caring arrangement.

178. At the end of November 2010, a blizzard arrived in the west of Scotland and bad weather continued for around a week. Placement agreement meetings which had been organized for 30 November 2010 and 6 December 2010 were cancelled as a result of the poor weather conditions. Thereafter, Stephen Lorimer was on annual leave from 9 December 2010 until 20 December 2010. He expected that the duty team would deal with any emergencies that arose during his absence but that routine work would not be dealt with in his absence. He was in touch with Mrs McKenzie by telephone on 1 December 2010 and also had feedback on the placement by email from Eileen Leber before going on holiday.
179. Given the cancellation of the placement agreement meetings, on 13 December 2010, Eileen Leber drafted a Placement Agreement in terms of Regulation 27(2) of the *Looked After Children (Scotland) Regulations 2009* and e-mailed it to Magdalene Sewell, asking her to arrange for signing of the Agreement, and in particular asking for her to arrange for MC to sign the medical consent form, the activities consent form and the photographs consent form. These consent forms and the Placement Agreement were never returned to the FCAS office. Ms Sewell signed the Placement Agreement and dated it 7 April 2011. The signed form was retained on the social work files.
180. The purpose of the placement agreement meeting was for the local authority, FCAS and the carers to meet and agree the day to day practical arrangements for child D, including issues such as contact, schooling, issues around pocket money and obtaining medical consents. This meeting was intended to allow all parties to clarify the expectations of their role within the agreement.
181. Eileen Leber maintained regular telephone contact with Dawn and Bryan McKenzie over this period and visited their home on 13 December 2010. She noted in her

supervision notes that “The decision to move child D was taken with some expediency due to the other carers’ circumstances and, therefore, was not managed as well as it could be, with little planning or preparation for child D.” However, Ms Leber was told by Mr and Mrs McKenzie that he had settled in really well and that he had made friends with their nephew Jordan, which had helped him settle.

182. Carole McGinlay returned to work on 5 January 2011. At this point she took over as supervising social worker for Mr and Mrs McKenzie. On 5 January 2011, she called Mr and Mrs McKenzie and arranged a home visit for 6 January 2011.

183. On 18 January 2011, a children’s hearing took place for child D and his half-sisters. The children’s hearing dispensed with the need for him to attend. Mrs McKenzie attended the hearing. This was the first occasion in which Stephen Lorimer met Mrs McKenzie. The children’s hearing continued the supervision requirement and varied the conditions. Mr and Mrs McKenzie were named as child D’s carers, with a non-disclosure of address stipulation. A condition that he should attend a school in the area in which he resides was made, as was a condition that he should be permitted to go on holiday in the UK, as deemed appropriate by the Social Work Department. Supervised contact for him was to take place once every two months for a minimum of two hours, separate from siblings and separately with MC and RR. This was the first time that the children’s hearing had stipulated that child D should have contact with MC and RR separately. The position of the Social Work Department by that hearing was that contact between child D and MC and RR should be terminated, a view that was endorsed by Safeguarder Gino Satti. As a result of the Hearing’s decision, believing that the decision in relation to contact was not in the best interests of the children, the Social Work Department requested an early review in order to address the issue of poor quality contact again. After discussion between Magdalene Sewell, Team Leader, and Liz Simpson, Service Manager, and after consideration of the views of the LAAC Mental Health Team and the Family Contact Assessment Service, it was decided that until the next children’s hearing took place, contact between the three children and their parents

would be suspended by the Social Work Department. The decision to suspend contact was taken in response to the behaviour of MC during the contact session in December 2010, which was considered to be detrimental to the interests of the children.

184. On 24 January 2011, Stephen Lorimer had arranged a home visit with Mr and Mrs McKenzie. That day, Mrs McKenzie cancelled the home visit because child D was ill and she had to collect him from school early.

185. On 25 January 2011, Mrs McKenzie visited FCAS's office in Hamilton with Carole McGinlay, during which time they spent around two hours reading records and paperwork relating to child D. Mrs McKenzie had access to the FCAS file, which, as well as FCAS paperwork, contained a number of local authority reports in relation to him including full assessments and care plans, housing department documentation dating from 23 October 2005 until 21 October 2007 outlining anti-social behaviour of child D and his brothers in the community over this period and a LAAC Mental Health Team assessment by Gillian Sloan and Suzanne McCrae. Ms McGinlay highlighted various pieces of information to Mrs McKenzie during this process, including his family history, the lack of care and protection of the children in the community, the extent of the lack of boundaries, the implications that this would have had for the children going into foster care and information in relation to the quality of his contact with MC and RR while accommodated. Mrs McKenzie was very attentive through this process and consideration of the file gave her a wider understanding of child D and his family.

186. Bryan McKenzie discussed with his wife the information that she had obtained at the meeting. He recalls that they were "pretty shocked" by the information and considered that this was information that they should have received prior to accepting the placement. He considered that having this information prior to accepting the placement would not have jaundiced his view of child D, but would have allowed them to be "better forearmed". Mr McKenzie was concerned that

child D could have been exhibiting behaviours as a result of events that had occurred in his past and that they would not have had the relevant knowledge relating to his background.

187. On 28 January 2011, Stephen Lorimer made his first home visit to Mr and Mrs McKenzie.

188. Regulation 46(2) of the *Looked After (Scotland) Regulations 2009* specify that a first visit to a child placed with foster carers must take place within one week of the placement being made. Thereafter, visits must be made within three months of the previous visit, in terms of the Regulations. In terms of GCC policy, looked after and accommodated children should be visited by the Social Work Department a minimum of every 28 days.

#### **The Placement with Dawn and Bryan McKenzie**

189. On 29 November 2010, child D moved to reside with Mr and Mrs McKenzie.

Children C and S moved to a placement with a GCC approved foster carer.

Although initially quiet and withdrawn when he arrived, by the time Stephen Lorimer visited him in placement on 28 January 2011, he had grown in confidence and made friends with Jordan Byrne, aged 14. He was registered with a GP and had attended a specialist clinic in relation to his Perthes disease.

190. He settled into a routine, enrolled at the local school, which he started attending after the Christmas holidays, made friends there and joined a local football team and a local youth club, and he participated in a boxing club for a while. Initially, his support worker continued to take him out for swimming and other activities, until April 2011, when it was decided that this extra support was no longer necessary for him. Mr and Mrs McKenzie and he regularly visited Mrs McKenzie's mother Ray Byrne on a Saturday night. On a Friday night, Mr and Mrs McKenzie and child D would regularly hire a DVD from the video shop and eat takeaway food for dinner.

191. Child D participated in activities and events with extended family members too, from both Mr and Mrs McKenzie's sides of the family, including Mrs McKenzie's mother and Mr McKenzie's parents. Bryan McKenzie described him as "hyperactive", a "bit of a tall tale teller" and a "typical teenage boy", who could be boisterous.
192. Bryan McKenzie does not recall child D ever enquiring about his previous foster carers or talking about his half-sisters. He occasionally mentioned his mother but did not say much. Mr McKenzie formed the view that he missed her, but had not been particularly happy at home. His bed-wetting continued and he was prescribed medication and was an outpatient at the enuresis clinic. The extent and frequency of the bed-wetting was variable over the course of the placement.
193. On 5 January 2011, child D was enrolled at school in Hamilton. His previous school had reported that he had no additional support needs. The school received no concerning information in relation to him from the previous school. He was described by staff members as "very polite" and he seemed to be very happy and settled within the school. His strengths lay in practical subjects such as woodwork and physical education. The school reported some minor issues in relation to behaviour in some classes and not doing homework, which were addressed by Mr and Mrs McKenzie. There were never any issues of significant concern in relation to him.
194. Mr and Mrs McKenzie were given advice and training in relation to discipline at the Skills to Foster training course. They were also given a hard copy of the FCAS foster carer's handbook, which addressed the issue of discipline. They would refer to this handbook as and when an issue arose. Mr McKenzie felt that the handbook advised a "softly softly" approach, which is the approach that they took. They explained to child D that they needed to know where he was at any given time, and needed to be able to trust him, so that they knew that he would come to no

harm. Mr McKenzie explained that there would be consequences to his actions, for example, if he came home later than agreed, he would have to go to bed early by way of sanction.

195. At application stage, Mr and Mrs McKenzie had drafted a Household Safer Caring policy, which addressed, *inter-alia*, mobile 'phone and internet usage. The policy stated that "As we would supervise all use of the internet, computer use would be restricted to the living room and would not be allowed in the child's bedroom. Parental restrictions will be used to ensure that the child cannot access inappropriate sites, and we will inform the child of the rules about how much time they can spend on the computer or internet, and we will advise them never to give out personal internet on the computer or by mobile phone." The policy further stated "We will give a mobile phone to a teenager, but not younger child. We'll also come to an agreement about their usage and expenditure, and our need to check on who they are phoning and texting." This was a general policy in place for the household, supplemented with the details of the foster child's individual Safer Caring Policy, to be drafted jointly by the carers and child once the child was in placement.

196. The Safer Caring Policy, which was signed off by Bryan McKenzie, Dawn McKenzie, child D and Eileen Leber, provided for the said child being allowed to use his laptop under direct adult supervision. In practice, he was allowed to use the laptop in his bedroom, on the condition that the bedroom door was open. The policy stated that child D would be allowed to go out of the house with Jordan, if agreed by Mr and Mrs McKenzie. He was to be taken out and brought back home by his carers.

197. During his placement with Mr and Mrs McKenzie, child D had contact with family members, including his mother, on 14 December 2010, 16 February 2011 and on 20 June 2011. These contact sessions took place in terms of the supervision

requirement made by the Children's Hearing and were supervised by social work staff.

198. On 22 March 2011, a children's hearing was convened for him. The Social Work Department sought a further reduction in contact between him and MC and RR. However, the supervision order was continued without variation.

199. On 4 April 2011, Katya Lamb, newly allocated FCAS supervising social worker for Mr and Mrs McKenzie, made her first home visit to the placement. This was an introductory visit. Ms Lamb recorded that everything was going well in the placement and that the issues raised by Mrs McKenzie related to child D's continuous bed-wetting and the fact that he referred to his foster carers as "mum and dad" at school and had told the school that they were his real parents. Following the meeting, Ms Lamb had a discussion with Alan McLeish, FCAS therapist, in relation to what extra supports were available for carers dealing with significant bed-wetting. Mr McLeish passed on information in relation to websites on bed-wetting that could be consulted. Ms Lamb also advised Mrs McKenzie to revisit the GP for local support and to alter child D's medication.

200. From 8 April to 11 April 2015, Mr and Mrs McKenzie and child D took a short break to Perth. Child D was dry at night during this break. Reports of the weekend by Mr and Mrs McKenzie were all positive. Mrs McKenzie and Ms Lamb discussed making plans for a holiday to Spain with him.

201. On 20 April 2011, Stephen Lorimer made a home visit to the placement. Child D appeared to be happy and content in placement. There were no presenting behaviours or issues that were of significant concern. Child D continued to participate well in the community with the clubs in which he was involved, and appeared to be more assertive than before. Mr Lorimer considered that child D was doing well, both within the placement and in terms of adhering to boundaries generally, taking direction and guidance from his carers, accepting the house rules

and attending school. He did not smoke, was not involved in criminal activity, took pride in his appearance, there were no current issues with his general health and he appeared to be having a settled period in his life. Some issues had arisen in relation to him returning home late, and Mr and Mrs McKenzie addressed this by putting sanctions in place. Mr Lorimer considered that their approach to sanctions and discipline was child centered and age appropriate and that child D was in a settled place where his needs appeared to be met and there were no significant issues arising.

202. On 20 April 2011, Mrs McKenzie attended a FCAS course entitled Safeguarding Children and Young people.

203. On 21 April 2011, Katya Lamb made her first supervision visit to the McKenzie placement. Child D's bed-wetting was discussed. Mrs McKenzie had followed advice given by Ms Lamb, but felt that the bed-wetting had worsened. She had also noticed that his pyjama bottoms had been dry while the bed had been wet and the possibility that this was a "sabotage technique" being used by him was discussed. Mrs McKenzie also reported that she had stopped him watching DVDs at night, and that he had complained that he felt that this was punitive. Ms Lamb discussed with her how to balance treats and the giving of rewards, alongside trying to make positive changes. Mrs McKenzie also raised the fact that child D was confused as to why he was not having contact with his half-siblings. Ms Lamb was not aware of the reason for this, but Mrs McKenzie told her at this meeting that a local authority social worker had told her that child D's sister child C had made an allegation, and that this was the reason for the lack of contact. Ms Lamb confirmed with Stephen Lorimer that contact between child D and his half-siblings had indeed been suspended as a result of an ongoing situation in relation to an allegation made by child C. Ms Lamb had an excellent working relationship with Mr Lorimer and was in regular contact with him in relation to a number of cases. In relation to child D's education Mrs McKenzie reported that she felt that overall,

he had settled well into school and that she would continue to liaise with the school and with this local authority social worker in relation to his education.

204. On 5 May 2011, a LAAC Care Plan Review for child D was held at Royston social work office and was attended by Mrs McKenzie, FCAS social worker Katya Conway, MC, RR, Stephen Lorimer and Magdalene Sewell. It was reported that Mr and Mrs McKenzie offered a good level of physical and emotional care, and child D was thriving in his placement, in school and socially, that he was attending a youth club, playing for a football club and had made friendships. He was reported to be a popular and confident child. At the meeting MC gave consent for him to travel to Spain in August for a holiday with Mr and Mrs McKenzie. It was also decided that two monthly separate contact sessions with MC and RR were to be reinstituted following the conclusion of the police investigation that had precipitated the suspension of contact. Mr and Mrs McKenzie felt that long term plans for child D should be arranged as soon as possible. Mrs McKenzie indicated that she and Mr McKenzie were willing to offer him a permanent placement. This had not yet been discussed with him as no final decision had been made about where he should reside permanently. MC indicated that she would fight any attempt to secure permanence for child D.

205. FCAS at this time used KDA forms, a weekly recording sheet for foster carers to complete in respect of each foster child's progress over that period. The information recorded would typically include information in relation to any concerns that had arisen about the child, illnesses, educational issues or achievements, contact with family, medical or other appointments, social activities, issues relating to emotional and behavioural development, respite or support issues, life story work and critical incidents. The form would be signed off by the foster carer and submitted electronically to the carer's supervising social worker. Prior to this, hard copy weekly recording sheets were submitted by hand to the supervising social worker.

206. In Mrs McKenzie's KDA form for the week ending 8 May 2011, she stated that "child D has a good upbeat feeling at present and is looking forward to going on holiday with us in August. Child D is increasingly voicing his opinion and is confident meeting new family members." Mrs McKenzie continued, in relation to a family event that she and he had attended, "child D asked if the children are our second cousins, does that mean they are our third cousins?"
207. On 10 May 2011, child D was interviewed jointly by the police and Social Work Department as a potential witness in relation to allegations made by his sister child C that she had been sexually abused by another family member. The joint interview took place at the McKenzie's home. Bryan McKenzie was present with him during the interview. At the conclusion of investigations into this matter, no action was taken in relation to the allegation. After the interview, Katya Lamb had spoken to Mrs McKenzie, who had indicated that the interview had gone "okay", that the police had been supportive and that child D had felt supported.
208. On 11 May 2011, Katya Lamb made a home supervision visit to the McKenzie placement. Mrs McKenzie discussed the fact that child D had been referring to her and Mr McKenzie as "mum and dad" on school paperwork. Ms Lamb discussed with Mrs McKenzie the positive and negative aspects of this. Ms Lamb considered that this was perhaps an indicator that he did not understand his own background and his relationship with his own birth family, which was ongoing. Ms Lamb also commented it was not unusual for accommodated children to refer to foster carers as their parents at school in order to normalize their situation and not stand out. Bed-wetting was still an issue most nights. Child D had been referred to the CAHMS team by the local authority (following the LAAC review) and had an appointment at Hamilton Community Clinic on 19 May. A discussion took place between Ms Lamb and Mrs McKenzie in relation to the possibility of escalating to a team parenting discussion or consultation in order to get some additional support in relation to this matter. In relation to child D's education, Mrs McKenzie reported that she and Stephen Lorimer had attended a meeting with the school to

discuss his Education Support Plan. There had been a vast improvement in his homework. Feedback from the meeting was positive in relation to the amount of support that Mrs McKenzie had been giving him at home. Ms Lamb also discussed with Mrs McKenzie the fact that she had stated that she would consider keeping child D on a permanent basis and that Mr and Mrs McKenzie had considered moving home in future in order to buy a property with more bedrooms to allow Mrs McKenzie to develop her fostering career. Mrs McKenzie was aware that she was going to be considered as an option for his permanent carer. Ms Lamb considered that "there was definitely a sense from both parties that what was going on was completely secure for both...parties, the parents and the child...the foster carers and child."

209. On 12 May 2011, at a Carers' Forum, Mrs McKenzie was given a copy of child D's birth certificate by Katya Lamb in a sealed envelope. Ms Lamb was not aware of the contents. Child D, who had been making enquiry over many months about his birth father, was shown the birth certificate. He was "shocked", to discover that a "DD" was recorded on the certificate as being his birth father. DD, at that time, was his maternal grandmother's boyfriend. He did not discover until speaking with his mother on 20 June 2011 that DD had been his mother's boyfriend at the time when he was born. Child D had understood at the time of being shown the birth certificate, that his birth father was a "JO". He spoke to Tom and Ann McKenzie about this issue. He was upset and withdrawn.

210. Mrs McKenzie recorded in her KDA form for the week ending 15 May 2011, that "child D asked lots of questions in regards to his birth certificate which he received. He seemed upset with the information on his birth certificate. He said his mum had lied to him, and the name on the birth certificate is not the name his mum told him in regards to his dad."

211. Ray Byrne stated in evidence that child D was upset by this discovery because “he thought he was a nobody” and had said to her “Who am I?” in the context of speaking of his paternity.
212. On 4 June 2011, a paintball party was arranged in Glasgow for child D by Mr and Mrs McKenzie. He had invited Jordan, Jordan’s friends, and some of his own friends from school, and was disappointed that none of his own school friends attended the party.
213. On 6 June 2011, Katya Lamb made a home visit to the McKenzie placement. Child D was present, and told Ms Lamb that he was happy in placement and looking forward to his holiday with Mr and Mrs McKenzie in Spain in August. Child D and Mrs McKenzie seemed very happy in each other’s company. Mrs McKenzie stated that she had submitted two babysitter request forms to allow her mother Ray Byrne and mother in law Ann McKenzie to help look after child D after school, or collect him if she were to be delayed after training and meetings. This had been approved. Mr and Mrs McKenzie did not, however, make use of respite placements or babysitters during their time caring for child D.
214. On 15 June 2011, a LAAC planning meeting took place in relation to child D and his half-sisters. The purpose of the meetings was for professionals involved in the children’s care to consider the long term care plan placement needs of the children. In attendance were Rosemary Murray, Team Leader, Jackie Wallace, social worker, Anne McCluskey, social worker with Families for Children, Stephen Lorimer, social worker and Magdalene Sewell, Team Leader. It was unanimously agreed by those in attendance that child D’s placement was meeting his needs and that there should be no plans at that stage for the placement to be changed. It was also agreed in the context of the circumstances of all the children that the three half-siblings should remain separated in the long term. By mid-June 2011, child D had made clear that he wanted to continue to live with Dawn and Bryan McKenzie in the longer term.

215. On 15 June 2011, Mrs McKenzie attended FCAS Safer Caring Training. At this course, she shared her concerns about children using Facebook, and this became a theme of the course. Katya Lamb, who was present at the training, later spoke to Mrs McKenzie in relation to how to manage the use of Facebook. Mrs McKenzie reported to Katya Lamb that child D had been in contact with his mother via Facebook. Mrs McKenzie was not sure how to proceed.

216. On 16 June 2011 Stephen Lorimer and Katya Lamb were contacted by Dawn McKenzie in relation to child D contacting his mother via Facebook. The local authority social work carefirst record stated that it was agreed that child D's laptop and mobile 'phone would be removed from him to prevent this contact from continuing meantime. Mrs McKenzie had already confiscated the laptop at the point when she contacted Stephen Lorimer. Stephen Lorimer told Mrs McKenzie to tell child D that this was a decision made by the Social Work Department, and that he would discuss the matter with him when he met him on Monday 20 June. Child D was not happy about this arrangement at all, and asked for his laptop and mobile phone back. He was told by Mr and Mrs McKenzie that they had to await further instruction in relation to when he could have use of these items again.

217. Stephen Lorimer did not envisage the confiscation of the laptop being an ongoing means of controlling the situation. He considered that with agreement amongst child D, the McKenzies and himself the laptop would not need to be confiscated on an ongoing basis.

218. The FCAS record in relation to this matter, as drafted by Katya Lamb, stated that "she [Dawn] discovered child D misusing Facebook, had made contact with his mother and two other relatives. Dawn worries this is undermining the placement as child D is not allowed contact with his family at the moment...I suggested to Dawn that she explains this to child D and moves his laptop into the lounge so his use of FB (Facebook) can be monitored. Dawn had already done this and she had

informed social worker, Stephen Lorimer, who had advised the same.” In evidence, however, Ms Lamb indicated that Stephen Lorimer had indicated to Mrs McKenzie that she should confiscate the laptop from child D. Ms Lamb said that she considered this to be a completely fair and appropriate decision in this context. Mrs McKenzie told her that child D was not happy with this decision, but that she felt that he understood the reasons for the decision. Ms Lamb stated that the decision as to whether and when the laptop was going to be returned at some point was a decision of the local authority. Ms Lamb never discussed the Facebook issue again or the question of returning the laptop to child D again, after the initial discussions with Mrs McKenzie.

219. On 20 June 2011, Stephen Lorimer met with Mr and Mrs McKenzie at their home and confirmed that he would discuss with child D the Social Work Department’s reasons that he could not have online contact with his mother. He intended to address the issue with child D and his mother together at the contact session that was scheduled later that day, and this discussion would be followed up with a telephone call to Mr and Mrs McKenzie afterwards. Stephen Lorimer’s Carefirst record of the meeting of 20 June states that “Dawn and Bryan stated their intention to supervise child D’s laptop use for the time being.” Bryan McKenzie has no recollection of this arrangement being made with Stephen Lorimer.

220. Mrs McKenzie recorded in the KDA form for the week ending 19 June 2011, that she had “removed both child D’s laptop and mobile phone” after discovering his unsupervised Facebook contact with his mother on 15 June. She stated that “child D accepted that his laptop and phone were being taken off him due to using his laptop to contact his mum. No conflict from him”. In the same KDA form, Mrs McKenzie recorded that “We’ve been talking to child D this week about trust and lies, and about how we find it difficult to believe him when he’s constantly lying to us. This is a big issue just now, although we’re managing this and continuing to work on it with him.” Mrs McKenzie further stated that “child D has been asking

about when he's going to be seeing his mum, as it has been ages since he last seen her."

221. On 20 June 2011, when child D was taken to contact with his mother, Stephen Lorimer discussed the issue of online contact with both of them. Child D indicated that he understood that he could not have online contact with his mother. Stephen Lorimer then telephoned Mrs McKenzie to give feedback in relation to the contact and the conversation in relation to the online contact. During this telephone conversation with Mrs McKenzie, it was agreed that child D could have access to his laptop again.

222. Bryan McKenzie stated in evidence that as at 20 June 2011, the Social Work Department had not instructed Mr and Mrs McKenzie in relation to what was to be done in respect of the laptop and mobile 'phone. He did not think they had heard what was to happen with the devices. On the day of the incident child D did not have his mobile phone with him because he wasn't allowed it.

223. Nothing is written in the diary, either on 20 June 2011 or any subsequent date, in relation to what was to happen in respect of the confiscated laptop and mobile 'phone. On that date Mrs McKenzie had contacted child D's pastoral care teacher at school to discuss the restriction of his internet use at school. It was agreed that he would be supervised at all times when working on a computer in class.

224. Stephen Lorimer was satisfied Mr and Mrs McKenzie had exercised sufficient vigilance in relation to child D's use of electronic devices. Mr and Mrs McKenzie acted appropriately in relation to monitoring, supervising and being vigilant in relation to child D's access to electronic devices and social media.

#### **Child D's Contact with Family during the placement with Mr and Mrs McKenzie**

225. On 14 December 2011, child D and his two half-sisters had contact with MC and RR at Royston social work office. When asked by RR how the placement was, child D

indicated that he really liked it. RR was not happy with this response. During the contact session, child C locked herself in a bathroom and refused to come out. RR behaved in a threatening and abusive manner towards social work staff in front of the children. Child S became upset. Child D told social work staff that he wanted to leave the contact session and Magdalene Sewell arranged for him to leave the contact session early. MC, became angry, shouting and swearing. She kicked a set of double doors so hard that the hinges of the door were broken. Magdalene Sewell was concerned by the high level of distress that was caused to the children, as well as being concerned for the safety of social work staff present at the contact. Bryan McKenzie stated that after contact, child D was "kind of on a high, that first night ...but after that, the next day and the next couple of days he was quite low again."

226. On 16 February 2011, child D had contact with his mother at Royston social work office and at a local McDonalds Restaurant. This was the first supervised contact that he had with his mother, outwith the presence of his half-sisters. This contact session was much more relaxed than previous contact sessions. Child D was anxious about contact and that he did not settle easily the night before. He told Stephen Lorimer en route to the contact session that he enjoyed where he was living and did not want to leave his present carers. Bryan McKenzie stated that after the contact session, "He would have come in kind of on a high, but it wis, it wis kind of strained. ... I never got the feeling he was ever happy when he came back from contact...I think it was very difficult for him, to be honest with you."

227. On 20 June 2011, child D attended a contact session with MC. During this contact session, which was supervised by Stephen Lorimer, she told him that RR was in prison for shooting someone and that she was going to have to move tenancy as a consequence of that shooting. She also told him that his brother child R was subject to a court imposed curfew. When asked by child D why the name "DD" appeared on his birth certificate as his father's name, when he understood his father to be a "JO", he was told by his mother that DD was her boyfriend at the

time when he was born. DD up until this point had only been known to child D as his maternal grandmother's boyfriend. Child D then asked what his father JO was like, and his mother said that he was a small fat man and that he was dead. She joked that child D inherited his good looks from her. Child D was returned home alone from this contact session in a Cordia escort car. He was not at any time debriefed by Stephen Lorimer after the contact session. Stephen Lorimer accepted that this contact session could have been handled better, with more preparation for child D and de-briefing afterwards. He could not however, know in advance what MC would say to child D.

228. Child D was "very down" after that contact session and his behaviour deteriorated the week after. In general after contact sessions child D would initially be elated, but the day after would be in a low mood for around a week, would not be as talkative as usual and would not seem his usual self.

#### **24 June 2011 – The Day of Dawn McKenzie's Death**

229. 24 June 2011 was the last day of the school summer term. School finished at 1pm. After school, child D went swimming and went to a McDonald's restaurant with school friends. He did not at this time have access to his mobile 'phone, as it was still confiscated. He borrowed a friend's mobile 'phone and called the house and his own mobile 'phone in an attempt to let his carers know where he was, but there was no answer.
230. Mr and Mrs McKenzie expected child D to arrive home from school just after 1pm, as the school was situated at the end of the street in which they lived. At around 3pm, Mr McKenzie started to look for him at the park. He eventually found child D as he alighted a local bus, on his way home. Mr McKenzie saw that child D's eyes were bloodshot and asked him if he had been "doing anything", querying whether he had taken any illicit substances. Child D told Mr McKenzie at this time only that he had been to McDonald's.

231. Mr and Mrs McKenzie took the view that as it was the start of the summer holidays, they would sit child D down, tell him that he could not lie to them, tell him that he was not going to be allowed out that night, that there would be no regular Friday night takeaway and DVD, and that he would go to bed half an hour earlier than normal. Mr and Mrs McKenzie told him that this would be the end of the matter and that they would “wipe the slate clean” given that the summer holidays were commencing. This they did.

232. Later in the afternoon Mr and Mrs McKenzie and child D drove to ASDA, where Mr McKenzie and child D dropped off Mrs McKenzie to do shopping. Child D was becoming more agitated, as he wanted to go out and play football. Mr McKenzie told him that he could not do so. Upon return to the house, child D said that he wanted to use his computer. Mr McKenzie told him that he could not have his computer, and told him to watch television instead. Mr McKenzie did not want to become drawn into an argument at this time. A short time later Mr McKenzie and child D collected Mrs McKenzie from ASDA by car. They had dinner in the house, and at around 7pm, Mr McKenzie left the house to spend the evening with his brother-in-law. Mr McKenzie stated that “things seemed okay” when he left the house that evening. Mr McKenzie would never have left his house if he had had any concerns about child D being violent that night.

233. At approximately 2006 hours on 24 June 2011 a call was received from the McKenzies’ landline via the ‘999’ system. That call was made by Dawn McKenzie, from her home address.

234. In response to this call, police constables Frank Thomson and Gary Thomson attended at the McKenzies’ home, arriving shortly after 2010 hours and being allowed access to the close by a neighbour from the opposite flat. The police officers were able to enter the McKenzies’ flat as the door was ajar. Upon entering, they saw Dawn McKenzie lying on the floor of the living room, covered in blood.

When asked by a police officer “who stabbed you?” Dawn McKenzie replied “ma son”.

235. The police officers and a neighbour who is a trained nurse administered first aid. Paramedics arrived at about 2016 hours and treated Dawn McKenzie. As treatment was given, she suffered a cardiac arrest and emergency cardiac treatment was given. She was then taken by ambulance to Hairmyres Hospital Accident and Emergency Department, with cardio-pulmonary resuscitation (CPR) being carried on throughout.
236. At Hairmyres Hospital Dawn McKenzie was treated with advanced life support measures including CPR, insertion of chest drains and administration of fluids for around 37 minutes. Despite these measures she was pronounced dead at 2140 hours by Dr Sarah Boxall, Registrar, Accident and Emergency Department, Hairmyres Hospital.
237. A post mortem examination was conducted on Saturday 25 June 2011 at Glasgow City Mortuary by Dr Julie McAdam and Dr Robert Ainsworth, both forensic pathologists. This examination revealed a total of ten stab wounds, including one that had caused death. This fatal wound was to the abdomen, had damaged the small bowel and then penetrated the abdominal aorta and the immediately adjacent inferior vena cava, both of which are major blood vessels. This would have caused rapid and profuse bleeding and ultimately death. The remaining wounds would have required medical treatment, but would have been survivable. Five of these wounds were to the arms and are likely to have been defensive in nature. Two further sharp force injuries were identified on the scalp, and the tip of a knife was recovered from one of these wounds.
238. Toxicological analyses were carried out by Dr Gail Cooper and Dr Karen Scott, both forensic toxicologists, on blood and urine samples collected during said post mortem examination. All analyses gave negative results.

239. Following said post mortem examination, the cause of death was certified as 1a)  
Stab wound of abdomen

240. The forensic pathologists also examined a kitchen knife with a blade measuring 19.5cm in length, with the tip broken off, which had been recovered on a couch within the living room of the McKenzies' home. In their opinion this knife could have inflicted any or all of the stab wounds identified on Dawn McKenzie.

241. At approximately 2025 hours on 24 June 2011 Police Sergeant Stephen McManus was on duty as patrol supervisor for QB sub division, Strathclyde Police. He had been made aware of an incident involving a female being stabbed, and at this time he was making his way to that address. While on Wellhall Road, he saw child D. He noticed that child D had a cloth wrapped around his hand. When Sergeant McManus asked "what was up" with him, he replied "I've just stabbed my foster mum". Sergeant McManus then cautioned him, and asked him what he had stabbed his foster mum with. Child D replied "a knife" and then confirmed that the knife was still in the house.

242. Sergeant McManus made his way with child D to the McKenzies' home. On Brankholm Brae, Hamilton, he met two further police officers who then detained child D at 2040 hours in terms of section 14 of the Criminal Procedure (Scotland) Act 1995.

243. He was interviewed at Hamilton Police Office from 0345 hours on Saturday 25 June 2011 by Detective Constable Erin Renwick and Detective Sergeant Alan Bankier. He admitted to stabbing Dawn McKenzie in the stomach, but denied stabbing her more than once. At the conclusion of the interview, he was cautioned and charged with the murder of Dawn McKenzie, to which he replied "*Ah only stabbed her once*".

244. On 22 June 2012 child D pleaded guilty to the culpable homicide of Dawn McKenzie. The charge to which he pleaded guilty was in the following terms:  
“on 24 June 2011 at ..... you CHILD D did assault Dawn Fiona Byrne McKenzie, c/o Hamilton Police Office, Hamilton, and did repeatedly stab her on the head and body with a knife and you did kill her.”
245. On 10 August 2012 at the High Court in Edinburgh, Lord Pentland imposed an extended sentence of 12 years on child D comprising a custodial part of seven years detention at such place and on such conditions as the Scottish Ministers might direct, followed by an extended period on licence of five years. This sentence was backdated to run from 27 June 2011, when he was first remanded in custody.
246. Child D had originally been indicted on a charge of murder. The Crown accepted a plea of guilty to the crime of culpable homicide on the basis of diminished responsibility following extensive investigations by both Crown and defence into his mental state at the time of the offence. In the course of these investigations, between 1 July 2011 and 15 June 2012 he was interviewed by a total of eight appropriately qualified clinicians practicing in the fields of child and adolescent psychiatry and psychology, forensic psychiatry and psychology and forensic child and adolescent psychiatry. Seven expert reports and two supplementary reports were produced as a result of these investigations and were considered by both Crown and defence. It was as a result of the weight of opinion expressed by these said expert reports that said plea was tendered and accepted.

#### **SOME SPECIFIC ISSUES RAISED DURING THE INQUIRY:**

##### **Approval of Specific Age Ranges and Blanket Age Range Approval**

247. Around 2006/2007, FCAS decided to change its policy of approving foster carers for limited age ranges, eg. 0-5 years, to a policy of “blanket” age range approval, normally 0-18 years, with a preference for a stated age group, eg 4-8 years.

248. By 2010, when Mr and Mrs McKenzie were approved as foster carers by FCAS, this new policy of blanket age range approval was in place and the normal practice was to approve carers to care for children aged 0 to 18 years, with a preference for a stated age group. In the case of Mr and Mrs McKenzie, the approval was for 0-16 years, with an age range preference of 1 to 8 years.

249. The current policy within FCAS, now Core Assets, is that carers are approved for as wide an age range as possible. This will normally be for 0 to 18 years, although it will be for 5 to 18 years in a household where there are smokers. A preference is no longer stated. Considerations around age as part of the matching process are now based on the carers' experience, life experience, any experience of working for or caring for children and whether the carers have their own children.

250. Estella Abraham, CEO of Core Assets in Scotland and Director on its board of directors, confirmed that the decision of FCAS to change from narrower age range approval to blanket approval occurred to avoid bureaucratic difficulties, as for example, in sibling groups, where one sibling was outwith the age range approval for the carers. It was not done for financial reasons. Ms Abraham confirmed that FCAS had taken on board Kirstie MacLean's recommendation that preferences should not be used in order to avoid ambiguity. [Kirstie McLean was an Independent Consultant to the Significant Case Review commissioned by Glasgow Child Protection Committee.] The decision to move from age specific approvals to blanket approvals around 2006-2007 was made by the agency decision maker in consultation with the board of directors, of whom she was a member at that time. No risk assessment was carried out as this change was considered to be a procedural process rather than an anticipated risk. Ms Abraham stated that she did not consider that there were inherent risks in blanket age range approval, and that the reason for moving to blanket age range approvals did not arise as a result of any recommendations made to FCAS by the Care Inspectorate.

251. The Fostering Network considers itself to be “the voice of foster care in the UK”. It is a charity that has been established in Scotland for 30 years and its membership consists of local authorities, independent fostering providers and foster carers. In Scotland, it has over 4000 foster care households in membership, which comprises almost all the foster carers in Scotland. All local authority foster carers are in membership and all but three independent providers, Core Assets (previously FCAS), NFA and Fostering Solutions, have their foster carers in membership. The foster carers who do not have membership through their fostering agency may take individual membership. The Fostering Network campaigns in fostering related issues and works with the Scottish government to develop policy and develop and change legislation in the area. It also develops training resources and delivers training for foster carers, runs focus groups, participates in reviews for the Scottish government and produces publications on fostering issues.

252. Sara Lurie, one of their directors, stated that the position of The Fostering Network is that foster carers should not be approved to care for children for whom they do not have the required skills to provide the very best care. Assessment should be rigorous and challenging and assessing social workers should have, along with the skills to make good assessments, the courage to state clearly where they feel that the carers do not have either the experience or skills to care for a particular age range, and resist pressure from the approving service to agree to blanket approvals in terms of age. In relation to “preferences”, The Fostering Network considers that the idea of carers expressing a preference within a wide age range is an inappropriate practice as it implies that a carer would prefer to care for children of a specific age range, but have the skills to care for all children. If a blanket age range is used then it would be better to refer to matching considerations rather than preference, which would more clearly identify a foster carer’s skills. Having carers approved with a wide age range increases the placement choices for children and young people in that the placing services can consider a wider range of carers. The customary practice of approving foster carers for an age range rather than for a particular set of identified skills goes against the knowledge that children reach

developmental stages at differing chronological ages. Children who are looked after, who may have had less than the best parenting, often experience some delay in development. Having a broad age range means that a young person who may be perhaps 14 years of age, but has developmental functioning of about the age of 7 or 8 years old, can be offered a wider range of foster carers. A carer approved for 12 plus may have skills in caring for teenagers but not in caring for younger children. The wider choice of available foster carers for a young person also increases the chance that they will be able to be placed close to their own community and so experience less disruption to their life, more able to remain at their established school and to maintain relationships with friends, family and others in the community. In a similar way to that described for children and young people, a wider age range can allow carers to have placements based on their skill set rather than purely on age, for example to care for children with learning disabilities who may need care more appropriate to younger children.

253. In terms of drawbacks to blanket age approval, the position of The Fostering Network is that for children and young people it is more likely that they will be matched inappropriately with foster carers who do not have the skills to meet their needs. The wider the age range that carers are approved for, the more important it is that fostering services are clear about the exact skills that those carers have, which may of course change and develop over time, and whether those skills enable them to meet the needs of a specific child, or children, being considered for placement with them. A drawback of a wide age range for carers is that they may be asked, and in some cases pressurized by their fostering services, to take children whose needs they are not able to meet and whose behaviour they do not have the skills or experience to manage. Such situations are not unknown in both the local authority and private sector and have a great risk that placements will break down causing distress and harm to both the child and foster carer, who may lose confidence and feel let down by their service. (There was no pressure applied to the McKenzies by FCAS in the present case.)

254. The Fostering Network considers that for fostering agencies, a broad approval range is a great advantage, increasing the pool of carers from whom to make matches when children are referred to them. For local authority fostering services it can reduce their need to make placements with the independent sector which they may perceive to be more expensive. In-house carers are more often likely to be within the local authority's geographical boundaries. For independent fostering services, having carers approved for a wide age range enables them to respond to a greater number of referrals for placement. Whatever part of the independent sector a service occupies, whether that is charity, profit-making, not for profit or voluntary, there is a financial imperative for IFPs to maintain income in order to continue to exist, and above that to improve their services, and placement fees form the greatest part of the IFP's income. A wider age range for foster services also allows fostering services to more easily arrange respite care for children when it is needed by existing foster carers for whatever reason. However, a wide range of approval means that fostering services must be stringent in ensuring that they make every effort to ensure that placement matches are appropriate to meet the needs of the child and do not put the foster carer or fostering household under undue pressure. This can mean resisting demands from senior managers to make particular placements, either to save money or to generate income, pressure that may be understandable but risks making inappropriate placements with the resultant impact on both children and young people and foster carers. In fact, the use of blanket age range approval is on the increase in all sectors.

255. The Care Inspectorate, when asked about its position in relation to age specific approval stated that "we would expect that fostering agencies will undertake realistic assessment of the capability of foster carers and, based on that, arrive at an evidence based view of the range of ages of children or young people for whom the foster carers can be approved to care. We would expect that approval would reflect that view, ie the view of the assessor. We would also expect the foster carer's individual placements and age range approvals to be subject to regular review."

256. The British Association for Adoption and Fostering (BAAF) represents agencies involved in adoption and fostering. It has a professional membership consisting of local authorities and fostering services. BAAF aims to further the interests of the professional development of adoption and fostering. BAAF works closely with The Fostering Network in producing resources for use by foster carers and produces research papers which are published. It also holds forums for the Chairs of adoption and fostering panels, to allow for the opportunity to share information and expertise in the area.

257. In relation to the issue of age range approval for foster carers, BAAF's view is that placements are more likely to break down where the foster child is not a good fit with the household, or where the child is outside the terms of approval, or is the opposite gender from the carer's gender preference. Foster carers are more likely to be negative about fostering if their preferences are ignored. If placements are made outside the terms of approval, that is regularly a significant factor in terminations of approval, allegations or complaints. Some carers will be better suited to certain age ranges. Ignoring this increases the risk of problems for all parties. One should not ignore people's relative strengths and limitations. Their view is that the terms under which foster carers are approved must be child-centred in terms of both safeguarding and welfare issues. A foster carer needs to have the skills and knowledge, resources and access to support that enables them to be child-centred. The age of the child will be one factor, but chronological age is a weak indicator of the range of issues that any specific child will face in foster care.

### **Finding a Foster Placement and the Matching Process**

258. When it is decided by the local authority that a placement is required for a child, the allocated social worker for the child would normally contact Placement Services (a department within GCC) and inform them of what is required. Information in relation to the child, such as background reports, care plans, education reports and

health service reports where relevant are sent to Placement Services to assist with the search for appropriate carers. The allocated social worker can give input into issues such as whether a placement should be found for the child and siblings together, how many other children there should be in the placement, and any other issues that relate to the welfare of the child.

259. The Placement Services officer will consider the child's profile and information passed on by the child's allocated social worker and will look within GCC's network of foster carers to identify a placement. Families for Children is the GCC department that assesses, recruits and trains foster carers for the Council. Placement Services would look within the stock of Families for Children for appropriate foster carers initially.

260. Where no carers are available who meet the basic requirements for the child or the sibling group, the child's allocated social worker will discuss the matter with his line manager, who will refer the matter to the Service Manager (previously known as "Operations Manager"). Where the Service Manager agrees, a purchased placement can then be sought. Placement Services will then contact one or more independent foster care agencies to find out whether they have any appropriate foster placements available that meet the required criteria. In practice, GCC will only approach one private foster care agency at a time to seek a placement.

261. When a placement is sourced from an independent fostering agency, Placement Services contacts the allocated social worker, who may meet with the potential foster carers in order to assess the suitability of the carers and the physical environment of the placement. Information about the child is shared with the potential carers at this stage in order that they may consider the suitability of the placement from their point of view.

262. The local authority (in this case GCC) is responsible for ensuring that a placement meets the needs of the looked after and accommodated child.

### **Training and Support for Foster Carers at Foster Care Associates Scotland**

263. Pre-approval training run by FCAS in 2010-2011 was called “Skills to Foster”. It consisted of three days of training, which included various training exercises, consideration of various scenarios and consideration of individual case studies. The course sessions covered basic information on topics such as attachment and promoting resilience, safer caring, allegations made by foster children, transitions, change and rejection.
264. The Fostering Network, which designed the “Skills to Foster” training course, does not consider this training as a means to providing carers with the whole range of skills that they will need in order to foster. They encourage and support fostering services to provide their foster carers with a range of training that will develop their skills, and consider that participants will need to receive induction level training on core topics. However they feel it is largely impractical to provide specialized training before children are placed, and that for many carers it is better to learn on the job and be able to put new learning into practice as they foster, so therefore do not advocate that specialized training must occur prior to placement. They also consider it vitally important that fostering services take great care in matching children to placements, particularly in the first months of a foster carer’s career, and regard it as poor practice to make placements outwith the carer’s preferred age range, or within age range but with complex needs outside the carer’s assessed skills, unless training in caring for these children has been provided, or is to be provided very quickly after placement, and a strong support system is in place.
265. BAAF’s view is that although training seems to influence carer morale, there is a lack of evidence that it influences outcome. Training might help if it assists a good and competent carer to feel more confident about expanding from one age group to another (usually to older children who are the most challenging), but is not the

answer to this issue. It is about setting proper and appropriate terms of approval and helping carers widen them as they gain experience and develop their skills, and even then only if they are motivated to do so.

266. The Care Inspectorate considers that training is of paramount importance in relation to all placements whether within or outwith preferred age range, so that foster carers are equipped with the necessary skills and knowledge to enable them to meet the needs of the children and young people placed with them. If an expressed preference in fact reflects a limited capacity in terms of age range, any necessary additional training should be discussed and recorded at the matching meeting, and provided prior to a placement outwith the preferred age range being made.

267. FCAS offers monthly support group meetings for foster carers. These are attended by foster carers and supervising social workers. The group offers an opportunity for foster carers to share experience, and discuss any problems that they are having, with other carers and helps provide moral support, practical support and build relationships with other carers. The supervising social workers can offer information in relation to any queries about changes within the organization and changes in relevant legislation. Dawn McKenzie regularly attended this support group.

268. When a child is in placement, the allocated supervising social worker should visit the placement at least once a month, and where necessary have telephone contact in between meetings.

269. There is core training for foster carers which it is intended should be attended within one to two years of approval. The subjects for the core training include safer caring, attachment, child development and promoting positive behaviour. Thereafter training is offered to those who have identified training needs. This type of training includes Crisis Prevention and Intervention (CPI) training which

demonstrates and rehearses ways of de-escalating situations where children and young people are becoming, or have become, aggressive or violent.

270. Foster carers also have access to the foster carer handbook, as a reference tool. This contains a whole range of information for carers, including what they can expect from FCAS, issues around respite, fees and managing the behaviour of children.

271. The Scottish Social Services Council (hereinafter referred to as “SSSC”), a non-departmental public body appointed by the Scottish government under the Regulation of Care Act 2011, regulates the education and training of social service workers in Scotland. It is responsible for development of the social services workforce in Scotland, working with employers to ensure that workers have the appropriate knowledge, skills and qualifications, to ensure that qualifications are up to date and to ensure that there are no skills gaps within the sector. The work development needs of foster carers fall within the remit of the SSSC. It is currently engaged in a project to develop a standard for learning and development in foster care. It is intended that this standard will in future provide a basis for the development of courses and qualifications in foster caring.

### **Pursuing Permanence for Child D**

272. “Permanence” is a term used in a social work context to describe measures taken both to ensure that children are settled in a permanent placement for the rest of their childhood, and that this is underpinned by an appropriate legal order. It implies that return to parents has been ruled out as not being in the child’s best interests. In terms of options, adopters, foster carers or kinship carers who are willing may be approved to offer permanence for a particular child or sibling group.

273. On 30 January 2009, a Permanence Review was held by the Social Work Department. Present were representatives from the Social Work Department, FCAS, the Family Contact Service, children D, C and S’s primary school and

nursery, and MC. The decision made was that rehabilitation of the children to MC and RR was no longer under consideration and that permanence was to be pursued. It was decided that long term arrangements were to be made for the care of the children and the Social Work Department was to pursue a phased reduction in contact with MC and RR in accordance with the needs of the children. The possibility of adoption for children C and S was being considered, and long term fostering for child D. Moving the children to local educational establishments was also to continue to be pursued.

274. Thereafter, on 30 January 2009, Scott McCabe referred the case to the Legal Services Department of GCC, which responded with a detailed note in relation to progressing the case for permanence. This note indicated, *inter-alia*, that any possible kinship placement possibilities should be considered. Kevin Brown, Operations Manager in January 2009, considered that the sooner permanence was achieved, the better it would have been for the management of the case and for creating a level of security and stability for the three children.

275. Between January 2009 and June 2009, the permanence plan did not progress because, in the first instance, the placement with Mr and Mrs McA was disrupted and the Social Work Department had to plan a move for the children. Also, the LAAC mental health team was not yet involved with the permanence process and would have required to be on board in order that they could inform decisions to be made in terms of the permanent placement and contact.

276. The move towards permanence was difficult to progress for several reasons, including the high number of children's hearings that were taking place and consequent time that required to be taken for preparation of reports required for these hearings, safeguarders being appointed at hearings, MC and RR appealing decisions, and MC and RR's hostile and aggressive behaviour towards social work staff. Facilitating contact sessions was extremely difficult to manage. The first two

placements broke down. It was accepted by social workers there was an element of “drift” in this case also.

277. Anne Ritchie, Independent Consultant to the Significant Case Review commissioned by Glasgow Child Protection Committee, considered this issue and concluded that “As time went on, the decision for permanence became submerged in other pieces of work to be completed... The decision to pursue permanence did not so much ‘drift’ as get derailed.” Ms Ritchie considered that the amount of time and energy that went into dealing with contact sessions and attempting to get contact reduced through the children’s hearing system “perpetuated the need for panels, the stress of those and dealing with the parents’ views, general anxiety for the children and the carers... This was a truly vicious circle. The potential solution was to marshal the arguments for permanence and placement before the sheriff, seeking the level of control of the situation that everyone knew was needed, but that required some protected time to do the work as day to day demands were overwhelming.”

278. While child D was in the care of Mr and Mrs Edwards, they told their FCAS supervising social worker, Christine Mitchell, that they were concerned about the lack of progress being made in relation to securing permanence for him and his siblings. Mr and Mrs Edwards reminded her that they were short term foster carers and that they did not intend to become permanent foster carers for any children.

279. At the LAAC review on 5 May 2011, Dawn McKenzie indicated that she and Bryan McKenzie were willing to be considered as permanent carers for child D. Although by mid-June 2011, the Permanence Order report for child D had been drafted and had been submitted to the local authority Legal Section, a permanent placement had not yet been sought for child D.

280. Since the death of Dawn McKenzie, mechanisms have been put in place by GCC to ensure that permanence cases are tracked, progressed and follow timescales. A

senior management review process is now in place as is a Permanence Forum which tracks the progress of cases, including the progress of preparation of permanence order reports, and discusses any issues or problems.

#### **Child D's Enquiries in relation to his Birth Father**

281. In July 2010, Fiona Edwards recorded in FCAS weekly recording sheets that child D had been asking her questions about his birth father, whom he knew was named "James". He had been interested in who his dad was, and had asked his mother, but had never really been given a proper answer. He had a yearning to meet his father, and to know who his father was. Mrs Edwards was not sure exactly what information child D knew in relation to his father, but he had asked to see his birth certificate.

282. On 3 September 2010, during a home visit, child D asked Stephen Lorimer if he would find out more about his birth father and speak to his mother on his behalf. Stephen Lorimer undertook to do so.

283. On 20 October 2010, social work records indicate that social work staff, including Stephen Lorimer, had a meeting with MC, learning that child D's father's name was JO, that he died in 2006 or 2007 of a heart attack, that MC had been in a relationship with him for two years, had thereafter broken up with him and had then discovered that she was pregnant (with child D) and that he had never met child D. JO came from a big family, was a carer for his parents, was a Celtic fan, was quite chubby and had blond hair. The record also indicates that MC was subsequently in a relationship with DD when child D was born.

284. At some point between 30 October 2010 and 5 November 2010, Fiona Edwards recorded in her FCAS weekly recording sheets that child D had been asking questions about who his birth father was and had asked when he would be able to speak to his mother about this. She made several attempts to contact the Social Work Department but did not receive a return call.

285. On 15 November 2010, Stephen Lorimer visited child D at the placement, and told him that his father's name was JO, and that his mother would give him more information the following week at one to one contact with him. This one-to-one contact session did not take place.
286. A CAHMS record of a planning meeting on 30 January 2011 indicated that child D knew that his father was deceased.
287. On 16 February 2011, child D and MC had one to one supervised contact. Neither raised the subject of child D's birth father, and it was not discussed.
288. On 21 April 2011, at a supervision meeting between Katya Lamb, FCAS supervising social worker and Mrs McKenzie, Mrs McKenzie told Ms Lamb that child D had shown a recent interest in contacting his birth father and had asked her to help him do so, but that latterly he had appeared to have lost interest in the matter.
289. On 12 May 2011, Katya Lamb passed Mrs McKenzie a sealed envelope which contained a copy of child D's birth certificate when she met her at a Carer's Forum, which Mrs McKenzie then let him see.
290. Stephen Lorimer recalls that child D was upset and angry that DD was named as his father on his birth certificate and accepted that it would have been helpful to debrief or to talk with him in relation to him finding out this information in relation to his birth father. Matters were finally discussed between child D and MC on 20 June 2011, referred to in Findings in Fact 227 on page 75 and 76 hereof.

### **The Challenges of Managing Social Media**

291. Managing access of looked after and accommodated children to social media is a significant issue for the Social Work Department. Managing online contact between children and their family members is an issue that can undermine

placements and cause unrest. (Mr Lorimer's view in evidence was that guidance or legal intervention was required to consider the issue in light of the fact that the child's right to access social media must be balanced with the right for the child to be safe and secure where they are living.)

292. The practical effect of looked after and accommodated children having access to social media is that they can have contact with family members that is neither permitted nor supervised in terms of formal contact arrangements. In relation to child D's online contact with his mother, it is not known what his mother had been telling him, whether they had been planning to have face to face contact, nor whether anything else of a concerning nature was being discussed.
293. By mid-2011, Stephen Lorimer had not received any training or guidance in terms of how to deal with social media issues arising in relation to looked after and accommodated children, and he felt that a lack of training and guidance continued to be an issue at the present time. There is now guidance available which he has seen, but he would welcome further training and guidance on the subject.
294. The practice now is that where there are concerns in relation to a looked after and accommodated child having unsupervised and unauthorized online contact with a family member, advice from the local authority Legal Section is to arrange for a multi-agency discussion, to include the foster carer, supervising social worker and children's rights service, because of the difficulty in balancing the needs and rights of the young person. It is not possible in practical terms to restrict the access of a teenager to the internet in the medium or long term. There is currently developing advice and guidance available to address this issue.
295. In terms of dealing with any problems in relation to an accommodated child using social media, FCAS discuss with the local authority about how best to approach the issue as the local authority holds statutory responsibility for the child. Guidance is sought from the local authority about what advice or safeguards they would want

put in place in relation to such an issue. Safeguards could include putting parental controls onto laptops or computers, limiting the amount of time that the young person spends on the internet, or only using the internet in the presence of the carer.

296. Guidance addressing issues arising from accommodated children using social media has been published by both The Fostering Network and BAAF. "Fostering in a Digital World: A Common Sense Guide" was first published by The Fostering Network in 2013 and "Foster Care and Social Networking: A Guide for Social Workers and Foster Carers" was first published by BAAF in 2011. These publications both specifically address the issue of unsupervised contact with family members through social media.

#### **Involvement of the CAHMS Mental Health Team with Child D**

297. Child D was first referred to the CAHMS community team in July 2005 by the Social Work Department, after concerns were raised at a case conference that he may be showing signs of Attention Deficit Hyperactivity Disorder. The referral was considered by North CAHMS team therapists, who concluded after investigation that he showed insufficient symptoms of ADHD to allow them to directly assess him. He was thereafter discharged from the service and MC and RR were referred to the PPP Parenting Programme to assist with parenting skills.
298. Child D was thereafter referred to the Forensic CAHMS (FCAHMS) service in June 2006 by the Social Work Department in relation to his behaviour within the community, specifically his involvement with gangs in the local area. The SNAP programme was identified at this time as being an appropriate intervention. MC and RR, however, failed to engage, and he was eventually discharged from the programme as a result of this.
299. In January 2008, child D was re-referred to FCAHMS, and the SNAP programme was again considered to be an appropriate intervention. MC and RR again failed

to engage with the programme, attending only one session. He was discharged from the CAHMS service in April 2008, as it was considered that he did not have a mental health problem, that his problems were behavioural, and that the Social Work Department was addressing and meeting his needs at that time.

300. Children D, C and S were referred to the LAAC CAHMS Mental Health Team by Scott McCabe on 29 January 2009. At this time, Mr McCabe requested assistance in relation to long term care planning, issues in relation to sibling contact and issues surrounding the impact of the effect of contact with the parents on the emotional and mental well-being of the children, with a view to informing the children's hearing.

301. Between November 2009 and January 2010, the LAAC CAHMS team carried out an assessment in relation to the impact of contact sessions with the parents for the three children. The report detailing the findings was submitted to a children's hearing in March 2010. The children's hearing, in part as a result of accepting the contents of this report, reduced contact from fortnightly to bi-monthly with MC and RR.

302. Fiona Edwards considered the LAAC CAHMS team to be very supportive and helpful, giving advice on dealing with difficult behaviours of the children. When Mr and Mrs Edwards decided to terminate the placement, she sought the advice of the LAAC CAHMS team in relation to how to manage this situation. There was discussion with Gillian Sloan in relation to whether child D would benefit from being placed separately from his half-sisters. It was agreed between Gillian Sloan and Mrs Edwards that if this was to happen, that contact between him and his half-sisters would have to be arranged regularly. Mrs Edwards felt that it was important for child D to feel that he was part of a family, as he could so easily feel left out or pushed out.

303. On 18 November 2010, during the notice period, Stephen Lorimer met with Gillian Sloan of the LAAC Mental Health Team. The change of placement was unplanned and there were concerns that this move may have a detrimental effect on the children, given that they appeared to have formed important attachments to Mr and Mrs Edwards. The children did not then know that they would have to change placement. Those present discussed the fact that the children had been with their present carers for 20 months and had made significant progress. They were going to have to change school, and they may grieve the losses that this change of placement would involve. It was agreed that support would have to be increased for the children and their new carers, and if the decision was to be that the children would have to be separated, due to a lack of carers available to foster the three children together, there would have to be regular contact between them. Ongoing concerns in relation to contact were also discussed. Child D was still being isolated at contact and child C was still struggling at the end of contact sessions. Concerns were also discussed in relation to RR threatening to video record the contact sessions. Gillian Sloan envisaged having ongoing involvement with the children as they moved placement. There was a plan to work with the new carers, although no specific plan to have individual input with the children. MC and RR were offered support in the form of advice and guidance, and declined. There were no imminent plans to see the children again at this point, but rather the intention was for the Team to continue to be involved on a consultative basis.

304. In further discussions between Gillian Sloan and Fiona Edwards, Gillian Sloan advised Mrs Edwards that the children should not be told about the change of placement until a couple of days before the move, as the move was going to be upsetting for everyone. Gillian Sloan suggested that Mr and Mrs Edwards could meet the children again once they had moved, to explain the decision for the children to be moved and to let the children see that they had not “disappeared”. Gillian Sloan suggested that Stephen Lorimer should be present when Mrs Edwards broke the news of the move, as the children may need his support at this

time. All were agreed that the children should not be told about the move until new placements were identified.

305. On 31 January 2011, CAHMS team staff and social work staff had a meeting about the case. It was reported that child D had settled well into his placement with Mr and Mrs McKenzie. The case was left open as it was felt that the family may require further support at a later date but direct care was not provided to him or to Mr and Mrs McKenzie. The Team reported that it allowed for a period of settlement with the new foster family before reassessing the need for intervention and closing the case. The CAHMS service had no further input in relation to him between this time and 24 June 2011.

### **Personae**

[19] Evidence at the Inquiry was led on behalf of the Crown for the public interest by Ms Carrie MacFarlane Senior Procurator Fiscal Depute of the Scottish Fatalities Investigation Unit. Parties were represented at the Inquiry as follows:-

1. Catherine Dowdalls QC for Glasgow City Council (GCC).
2. Ranald MacPherson Solicitor Advocate for Core Assets/Foster Care Associates Scotland (FCAS).
3. Ewen Campbell Advocate for Greater Glasgow and Clyde NHS Board.
4. Anthony Graham Advocate, and Louise Arrol Advocate for child D.

[20] At an early stage prior to the commencement of the evidence, Mr McClure, Solicitor for the Care Inspectorate indicated that it did not intend to be represented at the Inquiry. Prior to the commencement of the Inquiry I refused a request from Mr Moore, Solicitor for the natural mother of child D, to be represented at the Inquiry as it might impact on her contact with child D's siblings. I took the view that that was not the focus of the Inquiry. It

should be noted that that request was opposed both by Ms MacFarlane and by Ms Dowdalls and was not supported by any other party.

[21] Various reporting restrictions were also made on two separate dates to avoid identifying children under the age of 17.

[22] During the course of the Inquiry I heard from the following witnesses:-

Bryan McKenzie  
Ray Byrne  
Tom McKenzie  
Ann McKenzie  
Scott McCabe  
Wilma Dale  
Stephen Lorimer  
Michelle McAtear  
Magdalene Sewell  
Fiona Edwards  
Debbie Foley  
Linda Nicholson  
Valerie Lawrence  
Katya Conway  
Carol McGinlay  
Gillian Sloan  
Clare Flannery  
Christine Mitchell  
Eileen Leber  
Kevin Brown  
Fiona Mullen  
Thomas McLaughlin  
George Stevens  
Douglas McKinlay  
Carol Holden  
Fiona Sym  
Dr Marshall  
Anne Ritchie  
Dr Kerr  
Sara Lurie  
Mairi Anne Macdonald  
Kirstie Maclean

Colin Anderson  
Estella Abraham (Core Assets)

[23] In addition three Joint Minute of Agreements were lodged and there were a very significant number of productions both from the Crown (83 in number) and from GCC (14 in number).

## NOTE

### **Section 6(1)(a) – Date of Death**

[24] There was no dispute between parties and indeed it was incorporated into the First Joint Minute of Agreement that Dawn Fiona Byrne McKenzie, born 26 May 1977, died on Friday, 24 June 2011 at 2140 hours within Hairmyres Hospital, East Kilbride. Her life was formally pronounced extinct at this time by Doctor Sarah Boxhall, Registrar, Accident and Emergency Department, Hairmyres Hospital. Similarly there was no dispute that the incident which resulted in her death took place at her home address in Hamilton.

### **Section 6(1)(b) – Cause of Death**

[25] There was similarly no dispute between parties that in terms of the post mortem examination conducted on Saturday, 25 June 2011 at Glasgow City Mortuary that although Dawn McKenzie suffered ten stab wounds the cause of death was a stab wound to her abdomen as certified in the Post Mortem Report Production No. 1 for the Crown, by Forensic Pathologists of the University of Glasgow, Julie McAdam and Robert Ainsworth. It was similarly a matter of agreement between all parties that the wounds including a fatal wound were inflicted by child D, her foster child, who pled guilty to a charge of culpable

homicide on the basis of diminished responsibility at the High Court in Edinburgh and was subsequently sentenced there. The Toxicology Report carried out on Dawn McKenzie, referred to in Production No. 1, gave negative results for alcohol, prescription and illicit drugs.

**Section 6(1)(c) – The Reasonable Precautions if any whereby the death and any accident resulting in the death might have been avoided**

[26] It was submitted by the Crown that FCAS when considering if they had a suitable placement for child D when so requested to do so by GCC should have taken proper account of the McKenzies' status as new carers, and lack of suitable prior experience with adolescent aged children such as child D and accordingly not have recommended them as suitable prospective carers for child D. The Crown addressed the issue as to whether or not with hindsight this placement was appropriate and there are two separate strands to be examined. Firstly whether FCAS should have offered the placement to the McKenzies as their first fostering placement, and, secondly, whether or not GCC should have accepted the placement offered.

[27] Kirstie Maclean who is currently a consultant social worker, has very considerable expertise commencing in 1972 in general social work, children and families, and particular interest and expertise in the field of fostering and adoption. She had previously been a member of The Fostering and Adoption Panel, a member of the Social Work Services Inspectorate with the Children and Families Team, a Director of the Scottish Institute for Residential Child Care, the Service Manager for Family Based Care with the City of Edinburgh Council, managing all fostering and adoption services in Edinburgh, with

responsibility for the needs of children when they were accommodated, and latterly Chair of an Adoption Permanence Panel. She had undertaken a number of case reviews for local authorities, had been temporary Chair of a Fostering Panel, and I accepted she had very considerable experience and expertise in the area of fostering and adoption including the approval of foster carers and suitability of foster placements for looked after children. She had been involved to a significant extent in matching carers or adopters with children. She was requested by the Child Protection Committee of GCC to form part of the review team conducting a Significant Case Review into the circumstances of child D. She was particularly asked to look at the fostering aspects of the case, with respect to the operations of FCAS in regard to this case.

[28] Her counterpart on The Significant Case Review was Anne Ritchie, who was also an independent social worker with considerable qualifications and experience, with thirty five years of that in a supervisory or management capacity. Immediately prior to retirement from full-time employment in June 2012 she was the Head of Service for Children and Families in Criminal Justice with West Dunbartonshire Community Health and Care Partnership, and the Chief Social Work Officer for West Dunbartonshire Council. She chaired the Child Protection Committee for West Dunbartonshire Council and was the agency decision maker for adoption and fostering. She was a member and an individual member of the British Association for Adoption and Fostering, and the National Fostering Network. She also chaired Adoption Panel and Fostering Panels for two local authorities, and she had significant other areas of experience. As an independent consultant she was asked by the Child Protection Coordinator for Glasgow to become involved in The Significant Case

Review because of her experience. She was to look at the involvement of Glasgow Social Work Department and carry out a review of their actions in respect of this case. As a member of The Significant Case Review Team there were multi-agency discussions, including between her and Kirstie Maclean, but the focus of Ms Ritchie's report was on Glasgow Social Work Department.

[29] The Crown did not submit that GCC should not have accepted the placement offered as there seemed to be no evidence to support that submission. Both Kirstie Maclean and Anne Ritchie understood why GCC had accepted the offer of placement made by FCAS, and did not say they should not have. The Chair of The Significant Case Review, Mr Colin Anderson, also took that view having regard to the paramountcy of the best interests of the child. Mr Anderson was also a witness with extensive experience and expertise in respect of social work practice involving children, and is the current Chair of GCC's Child and Adult Protection Committee. None of these witnesses criticised GCC's acceptance of the placement offered and I accept their views in that regard.

[30] There are perhaps different considerations however to be applied when one considers the question of whether or not the offer of placement should have been made to GCC. It was unsurprising in the circumstances of the case that looking at matters from the perspective of the best interests of the child, not the carers, GCC acted appropriately in accepting the offer made – they were entitled to rely on the expertise of FCAS with whom they had a good working relationship and upon whom they had previously placed reliance. The said child D had formerly been in foster care placements with FCAS and no obvious

alternatives were available. The view appears to have been taken that the only alternative would have been a residential placement which was not desirable. No one appeared to take a contrary view when looking at the input of GCC in this regard.

[31] FCAS's position however is different. They were the body who had knowledge of the potential foster carers. They knew or ought to have known the McKenzies' background and, as narrated in the Findings in Fact, knew that this would be a first foster placement for the McKenzies, knew the limitations of their experience in that they were a childless couple albeit with some experience of caring, not on a permanent basis, for a nephew of Mrs McKenzie's, who was slightly older than child D and without his troubled background. They knew that Mrs McKenzie's experience was with children up to the age of five. They had information from the Form F, and ought to have had information available from the Fostering Panel. Unfortunately the allocated supervising social worker Carole McGinlay did not attend that Panel and in any event was absent due to illness at the time the placement was offered. Additionally a visit was carried out to their house by Eileen Leber who was the interim allocated supervising social worker for Mr and Mrs McKenzie. She had unfortunately not been involved during their approval process and had no previous knowledge of the couple. Debbie Foley and Christine Mitchell who had supervised large parts of child D's placements with Mr and Mrs Edwards were unavailable due to illness and maternity leave respectively. Eileen Leber herself was not satisfied with the information that she had, and for that reason felt that a visit to the McKenzies was necessary before they were offered the placement. There clearly was less information available both in respect of

the McKenzies, and in respect of child D to those who made the decision that they should be offered the opportunity to be foster carers for the child, than there might have been.

[32] In examining this area I need not be satisfied that the proposed precaution would in fact have avoided the accident or death, only that it might have done, and in addition that the precaution was a reasonable one. This falls to be applied objectively and with the benefit of hindsight. It has to be more than a remote possibility and the issue is not whether or not FCAS behaved in an unreasonable or reasonable way, but whether or not the precaution is a reasonable one and whether or not it might have made a difference.

[33] The precaution suggested by the Crown is essentially not to have offered the McKenzies as foster carers for child D. Clearly if that had not happened the death would not have happened. The killing of Mrs McKenzie by child D was an utterly unexpected and unpredictable event but that does not in my view preclude this Inquiry from considering whether or not the placement should have been made, even if the tragic consequences of the placement were never in contemplation and the worst that was thought might happen was placement breakdown.

[34] Whether or not FCAS ought to have offered this placement was considered by several of the expert witnesses in this Inquiry and in particular Kirstie Maclean, Anne Ritchie and Colin Anderson. Their expertise is referred to elsewhere. Mr Anderson took the view that the placement should have been made having regard to the paramountcy of the best interests of the child, but essentially he was looking at that from the perspective of GCC

and the best interests of the child. He was of the view that the alternative was a residential placement. He was aware that there were risks involved in making the placement, but he was clear that he would have supported the making of it, subject to fuller support from the local authority and FCAS.

[35] Anne Richie considered herself to have the necessary knowledge and experience to comment on whether or not the placement ought to have been offered by FCAS. She pointed out that they had knowledge of child D having had him in two placements before and that he was a known quantity to them and that as far as they were aware his behaviour was within manageable limits. She would have thought that Mr and Mrs McKenzie had the capacity to take child D on, but she would have hesitated because it was their first placement. She thought that what ultimately happened was unimaginably dreadful, so that outcome would not have been a concern, albeit other behaviour might have been, and might have led to placement breakdown which would have been a bad experience for the McKenzies. Although she described the process as a risk assessment it was more like an exercise of professional judgement. She looked at the perspective of those making the decisions and found the decisions understandable at the time. She did not criticise the local authority in accepting the placement offer but neither did she criticise Kirstie Maclean's views that the placement should not have been offered by FCAS and said that she understood them.

[36] It cannot be accurately said that this placement was outwith the terms of the approval which the McKenzies had. That approval was for zero to sixteen with a preference

from one to eight (although it should perhaps more accurately have been reflected as zero to eight). It was outwith the terms of the preference expressed and just whose preference that was, was somewhat vague. The McKenzies had described themselves as willing to take older children, although it is fair to say that they had not envisaged taking one of the age of child D. The approval which they had, also suggested that respite placements might be tried, and they were willing to take respite placements. There were few such placements available at that particular time of year, and there was evidence that respite placements themselves, albeit generally shorter, could be problematic. I do not think the fact that there were no respite placements before the placement of child D was made to be of great significance here. It was perfectly clear, and it was not suggested by anyone, that any of the workers involved were motivated by targets, money or other external factor and that all of the workers appeared to be acting in what they perceived to be child D's best interests. It was perfectly clear that they did not consider the placement to be a particularly risky or unachievable challenge. The workers had or should have had a reasonable degree of knowledge of child D. They had no legal liability to find a placement for him.

[37] However looking at the evidence of Kirstie Maclean, although she could see why the placement was made she considered that it should not have been. Her reasoning is contained in her Reports Crown Productions 23 and 49. She pointed out that the Fostering Panel's suggested option, of starting with respite placements, did not happen; this was a first placement for a childless couple who had little relevant experience to help them evaluate the appropriateness of the placement; the placement was a long way outwith their preferred age range and outwith their daily lived experience. She stated that the whole file

should have been read, although she recognised that that might not have made any difference; that the social worker involved, though helpful and supportive, had no face to face knowledge of the McKenzies and her knowledge of child D was out of date; that other workers were off sick or had moved and the knowledge of the McKenzies and child D was more limited than would usually be the case. To say that child D had no behavioural issues was inaccurate because although he was not the most difficult boy the agency had in placement, he had a number of problems, and his family background should have led to greater caution in assuming that he had overcome severe negligence, trauma and rejection. Also the actual placement process was much more rushed than it needed to be and lacked careful planning, and the child's social worker, because of annual leave and bad weather, played little part in the decision making, or once the move was agreed, in helping it take place.

[38] Ms Maclean analysed why the placement was offered and made, and the reasons were that this was a singleton placement; that child D was having to be moved from his previous foster carers and there was mounting concern about finding a suitable placement; that the staff felt a strong commitment to child D who they saw to be making good progress and to being a lovely boy and felt a genuine sense of responsibility to provide the next placement; that they had no other alternatives; that they may have been over optimistic about the therapeutic effect impact of settled family life, and that it was thought that the McKenzies had potential to be excellent foster carers. Those were the reasons Ms Maclean thought that the placement was made and on balance she thought that it should not have been. As stated above there was no indication that targets were being sought to be met.

[39] In essence what requires to be considered is whether or not a differing exercise of professional judgement can be said to be a reasonable precaution. That is quite a different thing from looking at professional negligence in terms of the principles of **Hunter v Hanley 1955 SC 200**. Mr Macpherson's submission for FCAS was that at the point of deciding whether to offer child D a placement with the McKenzies, a judgement had to be made, and that was a matter on which there might be legitimately be a range of opinions, all equally valid. That in fairness is demonstrated by the evidence because there was a range of opinion on this issue, albeit no dissenting opinion when one examines the issue from the point of view of GCC.

[40] However so far as looking at it from the perspective of FCAS is concerned, in my view it can fairly be said that had the factors enumerated by Ms Maclean been fully considered by them, and given appropriate weight from the point of view of what the foster carers were going to be asked to do, as opposed to what was in the best interests of the said child, I am prepared on the balance of probabilities to accept Ms Maclean's evidence that they should not have been recommended as suitable prospective carers for the said child D. This is not a question of professional negligence, it is a matter of a proper exercise of professional judgement taking full account of the facts which ought to be available and the full circumstances of the case. It does seem to me to be a reasonable precaution to have taken proper account of the McKenzies' status as new carers, their lack of suitable previous experience with children of the age of the said child D and the other factors enumerated by Ms Maclean and outlined in paragraphs [37] and [38] above, and having done so, not to

have recommended the McKenzies as suitable prospective carers for the said child. Given the perspective that Ms Maclean examined this matter from, her extensive expertise and her reasoning, and given the somewhat different perspective of Anne Ritchie, who did not criticise Kirstie Maclean's view although she herself might have taken a different one, and despite the differing perspective also of Colin Anderson, Ms Mclean's view appears to me to be correct. It is easy to say with the benefit of hindsight that because the match was made the death resulted, however that is not the legal test that requires to be applied. I accept Mr Macpherson's submission that the decision to offer this placement to the McKenzies was the exercise of a professional judgement. However the McKenzies were first time foster carers. This was a first placement. They had not experienced respite care. They had only limited experience in caring for Mrs McKenzie's nephew. They had no children of their own. Mrs McKenzie had experience of children from zero to five in the course of her employment. The said child was not a child without problems in his background and he did have problems in his behaviour to which perhaps not enough attention was paid because of the siblings. Taking account of all of these reasons it does not appear to me that the matching process was applied with sufficient rigour, and it does appear to me that FCAS, when considering if they had a suitable placement for child D when so requested to do so by GCC ought to have taken proper account of the McKenzies' status as new carers and lack of suitable prior experience with adolescent aged children such as the said child and accordingly ought not to have recommended them as suitable prospective carers for the said child.

[41] It appears to me that it is a “real or lively possibility”, to quote **Carmichael** paragraph 5-75, at page 174, that not to have made this recommendation in all the circumstances described might have avoided this death and that it was a reasonable precaution not to have made this recommendation.

**Section 6(1)(d) – The Defects if any, in any System of Working which contributed to the death**

[42] I was urged by the Crown to find that the system of “blanket” age range approval with an age “preference” also expressed that was in use in respect of approval of new foster carers at the time of the McKenzies’ approval was a defective system of working which contributed to Mrs McKenzie’s death. To enable me to do so I would be required to be satisfied that the defect in the system of working did in fact cause or contribute to the death. Such a finding was opposed both by Ms Dowdalls for GCC and by Mr Macpherson for FCAS. Mr Macpherson’s submission was that the decision to make this placement was not itself a system of working, it was a decision within a system of working. As I have stated briefly earlier, and discuss more fully at pages 137 to 144 hereof I agree with the submissions that this is not of itself a defect in the system of working which contributed to the death. The system of wide age range approval is practised, for what appear to me and are recognised by the Fostering Network and BAAF as cogent reasons. The reasons are also recognised by those who gave evidence to this Inquiry. The use of wide or blanket age range approvals has drawbacks as well as advantages but it seems to me providing the matching process is rigorously and properly applied the system itself is not defective. Accordingly I have made no finding under this section.

**Section 6(1)(e) – Any other relevant Factors**

[43] The Crown submitted that there were a number of other factors which were relevant to the circumstances of the death, and made submissions in respect of them. In addition, having taken the view that the system of blanket age range approval, with an age preference also expressed, that was in use in respect of approval of new foster carers at the time of the McKenzies' approval by FCAS was not a defect in a system of working, that is a matter on which it is appropriate to comment under this head also. The matters raised by the Crown and responded to by the other parties to the Inquiry are as follows:-

(1) The storage of knives in the foster home environment.

In giving evidence to the Inquiry and in her report (Crown Production 49 paragraph 7.4) Kirstie Maclean stated that the provision in foster carers' homes of a lockable knife drawer or cabinet was a precautionary measure that might have prevented Mrs McKenzie's death. It would be fair to say that in giving evidence to the Inquiry she recognised that such a requirement would upset the balance of normal family life and would present practical difficulties. It was recognised by all the witnesses that foster care should give the foster child a family life as near as possible to that in a "normal" home. As a matter of fact a knife was used in this tragic incident and as a matter of fact had a knife not been accessible it could not have been utilised as a weapon. The question really is whether or not such a precaution was a reasonable one. I have come to the view that it is not.

Of all the witnesses who gave evidence to the Inquiry, the only one who thought that it might be was Ms Maclean and she recognised the negative

aspects of such a suggestion. Serious consideration had been given to her suggestions by others including Anne Richie who pointed out that lockable medicine cabinets were not unusual, but ultimately after considerable reflection she had come to the view lockable knife drawers were not a practicable or reasonable precaution to be taken. A distinction was drawn between child proof locks on drawers for young children, and evidence was given to the Inquiry that the McKenzies had those in place as a precaution in relation to the children of friends of theirs. An inspection which was carried out of their home at the time of the completion of the Form F Report for health and safety purposes, found knives were not in evidence in plain view. No fault whatsoever attaches to the McKenzies in this regard.

The matter was perhaps best put by Sara Lurie of The Foster Network who stated, when asked what her thoughts were on locking away all knives in foster homes –

“It didn’t take very long to think or reflect on. It wouldn’t be achievable, it wouldn’t make sense. Fostering is to give children a taste of normal family life. We encourage, as part of the Safer Caring, foster carers should have child proof locks on drawers and things for young children. If somebody, if you were concerned about a teenager accessing knives, you might want to be concerned about whether foster carers is a right placement for them.”

Given the weight of evidence in this regard I have no difficulty in rejecting a suggestion that it would be a reasonable precaution whereby the death and the incident resulting in the death might have been avoided, to provide a

lockable knife drawer or cabinet in the McKenzie's home, and I have no recommendation to make in this regard.

(2) Crisis Prevention and Intervention Training

In relation to this matter a view was expressed by Ms Kirstie Maclean, that Mrs McKenzie had not at the time of her death had the opportunity of attending Crisis Prevention and Intervention Training and should have had such training at the outset of her career as a foster carer. Such training is provided by FCAS, and has the objective of assisting carers obtaining the skills to become attuned to an impending crisis, and to de-escalate such a situation and also the use of blocking strategies should an attack occur. Ms Maclean did not regard herself as an expert in this area. Additionally there was no evidence from which it would be reasonable to draw the conclusion that the provision of such training would have had the effect of making a difference to the tragic events which led to Dawn McKenzie's death.

The contention was strongly rejected by Ms Estella Abraham for FCAS, and it was submitted on their behalf that the court could make no finding to the effect that foster carers were exposed to a risk of any description as a result of the timing or content of their training and that the training was part of a process of becoming a competent foster carer. FCAS' position was that specialised training such as Crisis Prevention and Intervention Training was most appropriately given after the placement had begun, and gaps in

knowledge and experience could be identified and filled. The position was not the same as that where, for example, dangerous machinery or safety equipment was being used and the employee had to be given health and safety training before being allowed to use it. There it was submitted there was a foreseeable risk and training was necessary, not merely a reasonable precaution.

The view of the Fostering Network on this is largely in agreement with FCAS as they feel it is largely impractical to provide specialised training before children are placed, and they do not advocate that specialised training must occur prior to placement. BAAF appear to be largely unconvinced that training would assist. The Care Inspectorate feel that training is of paramount importance in relation to all placements to equip foster carers with the necessary skills and knowledge to meet the needs of the children placed with them.

With the benefit of hindsight however it is now known that tragedies such as that which befell Mrs McKenzie can occur in foster placements, and there is no doubt from the evidence which I heard that lesser attacks on foster carers can and occasionally do take place. The area of training of foster carers is clearly an important one. Whereas I am prepared to accept given the evidence which I heard, that Crisis Prevention and Intervention Training is more effectively given after foster carers have commenced their caring (it is

presently given after fostering for a year in the case of the primary carer and two years in the case of the second carer) Ms Maclean felt strongly that it ought to be offered to new carers at the outset of their fostering career because that was when they were at their most inexperienced or vulnerable. I find no fault with that argument. I can see no reason why such training cannot be given at the outset of a foster carer's fostering career and repeated perhaps to more effect after a year or two years when they have more experience. I heard no evidence that this would be harmful – at worst it might be ineffective. It appears to me to be important that foster carers at the commencement of their fostering careers are equipped with all knowledge with which they can practically be provided, to ensure their safety in carrying out their difficult task. Whereas it cannot be said that such training would have made any difference in Dawn McKenzie's case in my view such training should be given to foster carers at the outset of their career and repeated later. I heard no good reason why this could not be done, and recommend that it should. The Significant Case Review also took the view that such training should be given to carers of adolescent children, or those in mid childhood before their first placement started.

A review of foster carer training by the Scottish Social Services Council under the auspices of the Scottish Government is currently being undertaken and I understand that that work is well advanced. I understand that part of that training is to enable foster carers to take an SVQ qualification or similar. I can

see no good reason why Crisis Prevention and Intervention cannot be included in such training, and hope that the SSSC look at this issue.

(3) Progression of Permanence

It was clear from the evidence that the Inquiry heard that the decision taken to pursue permanence for child D and his siblings, after the decision was taken in January 2009 that the children would not be returned to their parents' care, became "derailed". Anne Richie, whose expertise is detailed above, carried out a detailed review of the involvement of Glasgow Social Work Department in this case and looked at what information there was, what action had been taken, what decisions were taken and how the case was managed up until the point of the tragic incident which led to Dawn McKenzie's death. She pointed out a number of factors as contributing to the delay in permanence planning and these are reflected in the Findings in Fact. These include the ending of the children's first placement which was due in no small part to the hostility shown to the then foster carers by RR and MC; the turnover of social workers for a variety of reasons including the hostility of the birth family to them; the workload that Mr Lorimer was expected to carry, which was extensive and in fact excessive; the case itself was particularly demanding due in large part to the behaviour of the birth parents; there were frequent Children's Hearings and appeals by the birth parents against their decisions; repeated opportunities given by the Hearings to the parents to improve their behaviour and care for the children;

difficulties over contact; and failure to write the Parental Responsibilities Report timeously, all largely because of work pressures.

There was evidence which I accepted that a new system of tracking cases where the goal is permanence has in fact been implemented by GCC, and this should mitigate against such a situation developing in the future. As referred to in Finding in Fact 280 on page 91 hereof, Permanence Forums now track permanence plans for children across all of Glasgow. That is as a result of ongoing awareness of better practice informed by other major inquiries, not specifically as a result of this case.

I was satisfied that there was no acceptable evidence that there was a causal connection between Mrs McKenzie's death and the lack of achievement of permanence for child D. Given the improvements that I am satisfied have taken place I have no recommendations to make in this respect. As Ms Ritchie pointed out –

“There is no doubt that the permanence decision here should have been progressed. Assuming that this had been successful in court, it would have, at least, given more control over contact and the day-to-day decisions that the parents were using to be obstructive. It would also have made a start on looking for a permanent placement. However, it is too big a leap to assume that a permanent family would have been found. It would not be easy to find a family capable of taking these three children with their very demanding individual needs and, almost certainly, some level of continuing contact with their parents ... In short, there was a great deal more to be done”.

As submitted by Mr Macpherson for FCAS, whereas the lack of progression of permanence is relevant to child D's progress as a Looked After and Accommodated Child, it could only be said remotely, if at all, to be relevant to the circumstances of the tragic death of Dawn McKenzie.

(4) The Role of the Children's Hearing System

As mentioned in paragraph 3 on pages 117 and 118 above (Progression of Permanence) one of the factors which was perceived as causing difficulty with permanence was that the Children's Hearings were perceived as listening to the parents and not being sufficiently child focussed.

Additionally it was suggested because there was no continuity in panel membership, that itself was a barrier to decisions being made in the best interests of the children. The evidence given to the Inquiry by the social workers who had been involved with the children, was to the effect that they had encountered a great deal of difficulty in persuading the Children's Hearings, as narrated in the Findings in Fact hereof, of the necessity to accommodate the children in the first place, and thereafter in restricting contact, a step which they saw as being in the best interests of children. They felt that insufficient weight was given to their evidence and that it was only once other professional input was sought, for example from the LAAC Mental Health Team, who re-affirmed what the local authority social workers were saying, that their recommendations were followed.

The lack of continuity of panel members meant that time had to be taken up at each hearing to deal with historical matters, because the new members were not familiar with the case. The social workers were also critical that the panels had given the parents repeated opportunities to demonstrate their willingness to engage and improve and Anne Ritchie agreed that the focus on the best interests of the children being paramount “did get lost at times”.

It did however appear to me that there were several reasons why that might have been the case. Evidence was given by some witnesses including Anne Richie that early on in this case there was perhaps a lack of confidence in social workers by the Children’s Hearing System due to very significant staff shortages in the Social Work Department, and concerns over the quality of some of the work being done by them due to the pressures workers were under. Further, the social workers concerned understandably looked at matters mainly from the perspective of what they felt to be the best interests of the children, and it is the case that the children’s natural parents were entitled to attend, be represented and make submissions to the Hearings which the Hearings were bound to consider. It is fair to say that there did appear to be some inconsistencies in decision making and on one occasion having appointed a Safeguarder, the Safeguarder’s recommendations were not followed. The Children’s Hearing System has however relatively recently been reviewed, new legislation has been passed in The Children’s Hearings (Scotland) Act 2011 and although their decisions had a bearing on the timing

of the accommodation of the children and the progression of permanence, so did other factors. I therefore have no recommendations to make in this regard.

(5) Provision of Information to Prospective Foster Carers

On the basis of the evidence which the Inquiry heard it is clear that at the very least Mr and Mrs McKenzie did not have at the outset all of the information about child D that they later required. That is accepted by Mr Macpherson on behalf of FCAS. There is however a divergence in evidence between what is said by the witnesses Eileen Leber and Linda Nicholson, who attended the meeting with the McKenzies at their home to give them information about child D, and the evidence given by Mr Bryan McKenzie, at least as to the amount, content and quality of that information. This was an issue that Mr McKenzie felt strongly about, describing being shocked when information was provided at a later meeting between his wife and Carol McGinlay at the FCAS Offices on 25 January 2011. Mr McKenzie described his wife telephoning him and being shocked at the information that she had been given about child D and his birth family.

Given the divergence of evidence which I heard on this subject, particularly on the issue of *enuresis*, the two versions are impossible to reconcile properly. I am prepared to accept that a lot of information was given, given the length of the meeting that took place, and the best that can be said is that given the

length of time since that meeting, the lack of notes that are available of it, the subject matter and the novelty of that to the McKenzies, a full and accurate picture of child D was not conveyed to them at that meeting. Much of the information that was given to the McKenzies appears to have been supplied shortly after that meeting, once the decision to take child D had been made by them, by the child's previous foster carer who spoke to this in evidence.

Whilst appreciating that the meeting took place as a matter of urgency given the lack of time that was available before child D had to move, it would have been good and useful practice for written information to have been provided for prospective carers to consider at their leisure and for detailed notes of the meeting to have been made and kept. Mr Macpherson made the point for FCAS that the amount of information that was in fact provided about child D was coincidental, because FCAS had previously dealt with him and his siblings in two previous placements, and if he had simply been in a local authority placement prior to this move, less information would have been available as he would have been entirely new to FCAS. That may very well be true, but the fact of the matter was that FCAS did have information, and could, and in my view should, have made that available in a digestible form, preferably in writing, to the new foster carers.

Mr Bryan McKenzie was impressive and honest and in my view extremely fair and balanced in the evidence he gave, particularly given the tragic events that had occurred. He was frank enough to state that he and his wife would

not have been dissuaded from taking the placement of child D, nor was he able to say that anything would have been different in the way that the McKenzies would have dealt with the placement had they had the better understanding of child D's background, which they subsequently obtained.

The issue of the information available appears to have been exacerbated by the fact that records were kept in different offices of FCAS, and that at the time of the placement, were not fully computerised. That I understand is no longer the case and it ought to make it easier to access all records relating to a child held by any office at the time of placement. That issue therefore to a large extent may have been resolved but in any event insofar as it is possible to do so, when a child is being considered by foster carers they should be given as much information as possible, in a digestible and understandable form, and in writing, to help enable them to decide whether or not to take the placement if made. It is my recommendation that that should be done in every case.

(6) Support of Foster Carers during Placement

There are two separate strands to this Inquiry in this regard, one being the support which should have been afforded to the foster carers by FCAS, and the support given to them by the child's social worker Stephen Lorimer and those who employed him in GCC. To an extent there is a degree of overlap. It was perfectly clear from the evidence that I heard that FCAS and GCC have

a good working relationship and that each had a high regard for the other, but for a whole variety of reasons the placement did not get off to a good start in respect of support. As narrated in the Findings in Fact hereof, the placement itself took place in a rush at the end. Child D was well known to both FCAS and to GCC Social Workers, and did not on the surface appear to pose particular difficulties, but it should have been anticipated that proper supports would be needed for him, and for the new foster carers caring for him. So far as the foster carers were concerned it was commented by various expert witnesses, including Kirstie Maclean, Anne Ritchie and Colin Anderson that additional supports should have been given to them to ensure that they were fully supported in their first experience of foster caring. So far as child D was concerned the view was expressed by at least some of these expert witnesses that the support given to him during the early stages of the placement was inadequate.

Whilst acknowledging that there were a number of difficulties at the outset of this placement in terms of support for child D caused by unusually severe weather, Stephen Lorimer being on holiday, staff illnesses and transfers and other pressures I agree with the view that the support from GCC Social Workers was inadequate. Regulation 46(2)(a) of the Looked After Children (Scotland) Regulations 2009 specifies that where a child has been placed by a local authority with a foster carer the local authority must ensure that the child and their carer are visited on their behalf within one week of the

placement being made, and thereafter at intervals of not more than three months from the date of the previous visit. That did not happen, and Mr Lorimer's first visit to the child in placement took place more than a month after the placement. The severe weather and Mr Lorimer's subsequent holiday arrangements, exacerbated by staff absence and illnesses and the time of year help explain, but do not excuse, this failure. If Mr Lorimer was unable to attend someone else should have attended on behalf of GCC, as soon as it was possible to do so.

What I also find concerning is that, although Mr Lorimer gave evidence that GCC's policy was for there to be a first planning meeting amongst the professionals within forty eight hours of a new placement, he seemed to be unaware of the policy and legislation in relation to the first visit by the social worker to a new placement. GCC policy thereafter is for the child to be visited every twenty eight days which is in fact more frequent than that required by the Regulations. His lack of familiarity with the 2009 Regulations is concerning.

Notwithstanding the lack of visits during the early days and weeks of placement there was telephone contact between Mr Lorimer and Mrs McKenzie early in December, and telephone and email contact between Mr Lorimer and Mrs Edwards, and also with Mrs Leber in which feedback on the placement was provided. Magdalene Sewell also spoke to Mrs McKenzie and

Mrs Leber on the telephone and Mrs Leber made a visit to Mrs McKenzie's home on 13 December and also saw the said child D at a contact visit on 14 December. The first occasion that Mr Lorimer met Mrs McKenzie was at a Children's Hearing on 18 January 2011, and he did visit the placement on 28 January 2011. He made further visits to the placement mid-February, 20 April and 20 June. He also met Mrs McKenzie at a LAAC Care Plan Review on 5 May, and at a meeting at child D's school on 10 May. There was also telephone contact between Mr Lorimer and Mrs McKenzie.

Valerie Lawrence who completed the Form F, and Eileen Leber in the handover paperwork, anticipated additional support being given to the McKenzies by FCAS. There was little evidence of any such additional support beyond what would normally be given, although there were regular visits by FCAS employees including Carol McGinlay, and sterling efforts were made despite the weather by Eileen Leber to attend at the McKenzie's house during the period of severe weather that was experienced shortly after the placement. There was also evidence of regular telephone contact by FCAS employees to Mrs McKenzie in particular.

Mr McKenzie was concerned at what he perceived to be a lack of support given to him and his wife, not just at the outset but thereafter, during the placement with them of child D. I think it would be fair to say that he was not fully aware of the frequency of contact that his wife had by telephone

with both Mr Lorimer and FCAS staff, and due to his work commitments he certainly saw a lot less of the FCAS staff and Mr Lorimer than his wife did, and had less contact with them.

There was a suggestion also that one of the reasons for a lack of additional support being given by FCAS was what was perceived as Mrs McKenzie's tendency to manage alone and desire to be seen as competent. However I heard nothing to indicate that Mrs McKenzie would not seek support when it was required nor did I form the opinion that in any way she wanted to "go it alone". I accordingly reject this suggestion.

In my view the reason for any lack of additional support during the placement, as opposed to at the outset, was the view that was held by virtually everyone that child D appeared to be doing extremely well in placement. Initially that may have been something of a surprise and was certainly a relief to those professionals involved. Everyone including the McKenzies, their parents, the FCAS workers and Mr Lorimer thought that the placement was going well. Giving evidence to the Inquiry Mr McKenzie, his parents and Mrs Byrne all described the placement with the said child D as going well. Mr McKenzie confirmed that he and his wife had thought that child D should stay with them as permanent carers and he was of the impression that child D was becoming a "thoroughly decent wee boy". Mrs McKenzie had stated to Mr Lorimer that the said child was "no problem to

care for” and the child had told Mr Lorimer that he was happy living there.

The fact that the said child appeared so settled was a relief to GCC social workers dealing with him and to the FCAS staff dealing with him.

Everything seemed to be going very well and the said child appeared to be a “nice boy” who did not display signs of aggression or violence towards his carers. His previous foster parents had indicated that they had never felt aggression or at risk from him. No one thought he was capable of causing harm to others of this nature. It was thought by Ms Anne Ritchie and Ms Kirstie Maclean, and by the social workers, that at highest the risk was the placement might break down and the McKenzies might become discouraged as foster parents. There was nothing that I heard in the evidence which would have indicated that people ought to have foreseen at the time that the said child D posed a risk to the people who were looking after him or that he was capable of such violence.

Because child D seemed to be doing so well it is understandable that the level of support being provided, particularly by FCAS, was felt by them to be adequate. It is fair to say they did have a support worker, George Stevens, who was familiar with child D and who kept working with him for a period of time after the placement commenced, having worked with him in his previous placement. Mr Macpherson made the point that what support will be needed in a placement must depend on the particulars of the placement itself, and on the surface the placement appeared to be going well and there

was regular and comprehensive communication between Mrs McKenzie and FCAS. It is also fair to say that there is no evidence that Mrs McKenzie felt any lack of support from FCAS during the placement.

With the benefit of hindsight and the benefit of expert opinion from Dr Marshall and Dr Kerr, the very fact that the child seemed to be doing so well, and in particular the fact that he showed so little upset at moving from one set of foster carers to another, perhaps ought to have been a warning sign that things were not as good as they seemed. Dr John Marshall is a Consultant Child Forensic and Clinical Psychologist with very significant experience in providing expert opinion, on *inter alia*, child and adolescent defendants. He has significant other qualifications and a very impressive CV. Dr Eleanor Kerr is a Child and Adolescent Psychiatrist with very significant experience and a most impressive CV in this field also. She prepared a report on the question of diminished responsibility during the criminal proceedings against the said child, and both she and Dr Marshall gave evidence that at the time of the attack on Dawn McKenzie the child was suffering from an episode of dissociation, a temporary abnormality of his mental state. I heard no evidence to the contrary and have to accept that. As to what had caused that dissociation, Dr Kerr took the view that a number of factors had caused the deterioration of his emotional state running up to the offence, including the confusing information about his birth father, angry feelings towards his mother, difficulties with his peers, the removal of devices important to him

and connected to his mother (namely the computer and X-box given to him by her) and the fact that his mother gave him unsettling information at a contact visit four days prior to the attack. Dr Kerr was of the view that child D demonstrated a disorganised attachment disorder mainly caused by what he experienced as a child in his family of origin. She gave evidence that neurological damage could be caused at an early stage which caused a fundamental alteration to the stress response. In her report she went into the reasons why such neurological damage was caused, describing that in effect, a person who had such a disorder when experiencing high levels of stress would stop displaying a response to it almost as a defence mechanism. She described “hypo-arousal” where the person concerned would have a depressed response, become withdrawn and less able to control their thoughts and feelings and appear to look quiet. One of the other effects was that a response to a perceived threat would happen much more quickly than with an ordinary person. Dr Kerr’s Report which is Crown Production Number 44 considered three main issues – (1) firstly, how issues identified in child D’s time as a looked after child and in fostering placements would have impacted on his mental state, and in particular the dissociative state he suffered at the time of the death, (2) to give her own opinion on that mental state at the time of the offence, and (3) to consider whether or not the Child and Adolescent Mental Health Services (CAMHS) input could have done anything more to prevent the fatality.

From the evidence given by Dr Kerr it is clear that any emotional and behavioural disturbance shown by child D during his involvement with CAMHS did not meet the diagnostic criteria for a child psychiatric disorder for which CAMHS treatment was recommended. She was firmly of the view that it was not possible for specialist children mental health services to predict or prevent the tragic event that occurred. Her view was that current day research, most recently a Report dated November 2014, was only beginning to understand the effects of early deprivation in children, so even if the view that child D was doing so well in his placement was one which might now raise alarm bells, it certainly would not have done so at the time of the tragic events in 2011. No one could have foreseen what happened. Everyone thought the placement was going well, and at the time the supports were thought to be adequate.

For the foregoing reasons therefore it cannot be said that there is any causal connection, between the failure of GCC to meet the requirements of Regulation 46(2)(a) of the 2009 Regulations, or to be in more frequent direct personal contact with the said child D and the McKenzies thereafter in the months leading up to Mrs McKenzie's death, and the death itself, albeit I take the view that the support given by them was inadequate, in the early stages. Similarly it cannot be said that there is any causal connection between the death and any lack of support given by FCAS – I am not even certain that it is fair to say that there was a lack of support by FCAS in this case. Perhaps

more could have been done, but there was a lot of contact by telephone, and Mrs McKenzie was invited to and did attend training with particular enthusiasm, and appears to have been particularly good at it, having even been asked to assist with training by Katya Lamb.

GCC Social Workers are aware of their shortcomings in regard to support in this case. There is no causal connection that I can find with the death, because parties could not reasonably have been aware of or predicted child D's mental state or his actions on 24 June 2011. Given increasing knowledge, awareness of the need to be wary of children's unusually good behaviour when it is not in keeping with their experiences is now heightened. I have therefore no recommendations to make in this regard.

(7) Management of Social Media

In looking at the possible causes for child D's behaviour the issue of his contact with his mother via social media and the issue of discipline following thereon was discussed by witnesses. The evidence was to the effect that immediately on discovering that he had been in touch with his mother by way of social media Mrs McKenzie behaved entirely appropriately and contacted the child's social worker Mr Lorimer, and her own FCAS worker Katya Lamb as soon as it was possible to do so. The child's access to his laptop as well as his X-box machine which had a live internet function was withdrawn, although it was not entirely clear as to whether or not access to

his mobile phone was also withdrawn. Mr McKenzie's evidence was to the effect that it was, and this was to an extent confirmed by the child's version of events on the day Mrs McKenzie was killed. Given the state of knowledge of parties at the time, there is no doubt that the steps to remove internet devices were regarded by all concerned as an appropriate one, as a short term solution. Mr Lorimer gave evidence which I accept that there was a discussion between him, the child and the child's mother on 20 June 2011 when the difficulties with such contact were pointed out, including that such contact was in breach of supervised contact arrangements in place. Thereafter the evidence becomes somewhat unclear, Mr Lorimer being of the view that the laptop was to be returned to the child with its use supervised, and Mr McKenzie's recollection being that it had not been returned by 24 June 2011. Mr Lorimer's recollection is not confirmed by an entry in the Care First Records and there may very well have been a misunderstanding. Mrs McKenzie's detailed record (and she was normally meticulous in her recording) does not confirm Mr Lorimer's position about the returning of those items, and Mr McKenzie was adamant that the devices remained confiscated, which is supported by indirect evidence about the child and his efforts to contact Mrs McKenzie on 24 June 2011. I am prepared to accept that the laptop may have been returned before 24 June but at the very least the situation is confused. There is nothing to suggest that Mrs McKenzie would have disregarded advice or instruction given to her – on the contrary she always took on board such advice.

The situation in relation to social media has moved on since 2011, and this is still a developing area, and is a problematic one for all those working within fostering and adoption. There is no doubt that the difficulties in a foster carer setting is recognised by the professional bodies concerned and I accept that FCAS have this matter fully in mind in the consideration and development of its own policies and procedures, and training. There is now published guidance by the Fostering Network and the BAAF although awareness of that appears to be limited. The prevailing view seems to be now that contact by way of social media between children and their parents will be impossible to prevent, and that the best way to police this in future may be by way of being open about the contact, and giving advice in respect of it and monitoring it.

It was submitted by Mr Macpherson for FCAS that although these facts in relation to the laptop and phone were associated in time with the death, they are not properly facts relevant to the circumstances of the death. I take the view that they are, because they were given as a reason by child D, when he was talking to Dr Marshall and Dr Kerr who examined him, for feelings of resentment which he harboured and which may have contributed to his attack on Dawn McKenzie. The issue is only significant with hindsight however, and it is not possible to say how dealing with it differently might have changed things.

As stated there are now training materials available, and social workers giving evidence, in particular Mr Lorimer, indicated that they would welcome further training on the issue. This is an area that should be looked at by those employing foster carers, to ensure that the best guidance available is given to them. Given the review of training that is currently underway this is an area that could also usefully be considered by the Scottish Social Services Council in the review of training which they are currently undertaking. However given that guidance and training are now provided in this evolving area, in this regard, I have no recommendations to make.

(8) Information about Child D's Birth Father

The Crown's submissions in this regard were to the effect that the situation about child D's efforts to find out information about his biological father could have been better handled by the professionals involved. There was evidence to the effect that child D had been making efforts to find out about his biological father for approximately a year prior to Mrs McKenzie's death. It appears that he was shown a copy of his birth certificate by Mrs McKenzie which was passed to her in a sealed envelope by Katya Lamb when they met at a training course on FCAS premises. Ms Lamb had no recollection of this and I accept that she was not aware that she had done so given she had handed over a sealed envelope, but given Mrs McKenzie's diary entries I accept that she did in fact do so. The envelope may have been forwarded by a previous carer but in any event I am prepared to accept that the birth

certificate was handed over inadvertently, and in those circumstances I do not accept that there should be any criticism of Ms Lamb in this regard.

The information about child D's biological father must have been confusing for him given that the name that had appeared on his birth certificate was not the one he had expected. Following on that disclosure child D continued to make enquiries intermittently, and Stephen Lorimer said that he would deal with the matter. There was then a delay until he met with his mother on 20 June 2011. Mr Lorimer accepted that that meeting could have been handled better because MC did not present child D's natural father in a positive light. With the benefit of hindsight, from the evidence of Dr Kerr and Dr Marshall, the potential impact of this on the said child was significant, and was not appreciated at the time. Mr Lorimer could and should have been better prepared for this meeting, however it is not possible to say that this episode had any significant bearing on what happened, and certainly not a foreseeable one – it is simply one other factor that may have had an impact on the said child's thought processes. It is not possible for this Inquiry to say what that impact might have been. Accordingly there are no recommendations that can be made in this regard, although it was not handled well or expeditiously by the social worker involved, and more should have been done to support the child after the meeting with his mother on 20 June 2011 rather than just sending him home on his own. Dealing with the matter more expeditiously and sensitively could only have been helpful.

(9) The System of “Blanket” Age Range Approval with an Age “Preference” used in respect of the Approval of New Foster Carers

Although I have taken the view that the foregoing system was not a defect in a system of working which contributed to the death of Mrs McKenzie, in my view it requires to be commented upon as a factor which is relevant to the circumstances of her death. A considerable amount of evidence was given to the Inquiry about this, and it was a practice which as I understood it from the evidence of Ms Anne Ritchie, Ms Kirstie Maclean and others is becoming even more prevalent, particularly with local authorities. There are several perceived advantages in such a practice to those who seek to find foster carers for children.

In the course of the Inquiry a considerable amount of evidence was given in relation to the age range for which the McKenzies were approved, and as reflected in the Findings in Fact they were approved following their assessment and Panel, to foster children between the ages of zero and sixteen with a preference between the ages of one and eight. It was not entirely clear whether or not the preference expressed is that of the carer or the assessor, or whether it is a combination of the two, and how much weight is to be attached to it. Ultimately the approval given to the foster carers is done by the Panel which they attend following on the Form F Assessment referred to in the Findings in Fact. Valerie Lawrence, who prepared the Form F Assessment, said that the preference was a matter of her professional opinion

taking account of the views of Mr and Mrs McKenzie. Mr McKenzie gave evidence, which I accepted, that given his wife had considerable experience of dealing with nursery-aged children, she wished to stretch that experience. They also had some experience of looking after their nephew while he was growing up, and he was at the time of the making of the placement a few years older than child D. Because Mrs McKenzie wanted to increase her experience, they felt that zero to eight was appropriate and Valerie Lawrence appears to have agreed with that assessment.

So far as the Panel Minute is concerned, the panel members unanimously recommended that the couple be approved as short term/respite foster carers for one child or two siblings within the age range of zero to sixteen years (preference for one to eight years) and the panel members also suggested to the couple that it could be helpful to undertake some respite.

I was given several reasons why wide age range approval (currently zero to eighteen years for FCAS) was appropriate. These were perhaps most clearly set out by Sarah Lurie of the Fostering Network and are reflected in Findings in Fact 251-254 on pages 82 to 84 hereof. There was no doubt, and it was accepted by Ms Kirstie Maclean, Ms Anne Ritchie and others, that it was administratively considerably easier to operate within a wide age range approval. For example, if an age range approval was from zero to nine and it was wanted to place a ten year old child with the foster carer concerned, it

was necessary to go back to the Panel to have the age range extended, except in certain short term circumstances. Similarly if a child stayed in foster care in one placement for a lengthy period of time and got older, that child could attain an age beyond the carer's current approval and again that would necessitate a return to the Panel for an alteration of the age range approval. It was also pointed out that a child's developmental age and chronological age are not always the same, and to use restrictive age ranges would not reflect that factor which could in some cases be significant. There could also be difficulty with siblings in those circumstances. There was evidence which I accept from Estella Abraham that FCAS's use of blanket age range approval was not for financial reasons, but simply to avoid bureaucracy. FCAS had taken on board the views of the Significant Case Review and stopped using preferences, which they accepted were not necessary and sometimes confusing.

So far as the use of blanket age range approval was concerned, both Ms Ritchie and Ms Maclean had serious reservations about it. Ms Maclean accepted that children's emotional and chronological ages might not be the same, but pointed out that could mean you could have an older, bigger, and stronger child with a much younger emotional age. She stressed that the important thing was the match. Matching is the process whereby the needs of the child are fitted to the abilities of the foster carers. In an ideal world there would be a choice of foster carers. From the evidence which I heard in

reality there is often no choice at all. There is a shortage of foster carers which varies from time to time but is always nonetheless a shortage. Ms Maclean pointed out that if a wider age range approval was used, very careful consideration had to be given to ensuring that the foster carers had the skill and knowledge to fit the needs of the child. She had significant concerns about a blanket policy. She was prepared to accept that with local authorities more flexibility was the reason for it, and she accepted that properly acting professionals did use blanket approvals.

The Fostering Network's views again reflected in the Findings in Fact hereof are that foster carers should not be approved to care for children for whom they do not have the required skills to provide the very best care. Assessment should be rigorous and challenging and assessing social workers should have, along with the skills to make good assessments, the courage to state clearly where they feel the carers do not have either the experience or skills to care for a particular age range and resist pressure from the approving service to agree blanket approval in terms of age. They go on to state that if a blanket age range was to be used then it would be better to refer to matching considerations rather than preference, which would clearly identify a foster carer's skills. Ms Maclean endorsed that position. In doing so she accepted the key was to match the individual skills in the assessment with the needs of the children concerned. She had recorded and considered the views of various bodies in her report Production Number 49 for the Crown in respect

of their professional opinions, and any known research findings on the advantages or drawbacks and risks of approving carers for children and young persons within an age group of zero to eighteen, with them stating their preference within that range. BAAF's response was that there were no research findings and to the effect that placements were more likely to break down when the child was not a good fit with a household or outwith the terms of approval. They did state –

“A foster carer needs to have the skills and knowledge, resources and access to support which enables them to be child centred. The age of the child will be one factor but chronological age is a weak indicator of the range of issues that any specific child will face in foster care”.

The Fostering Network as outlined above stated the advantages of wide age range approval included increasing placement availability and choice, and they also pointed out the fact that chronological and developmental age may not be the same. There were also financial advantages for foster carers, many of whom depend on caring as a source of income. If they are more likely to be used they will have a consistent source, which makes them more likely to be foster carers, and the pool of carers would be increased. There were significant drawbacks if children were matched inappropriately, the risk being perceived to be placement breakdown causing harm to both the child and foster carer.

The Care Inspectorate also provided a response stating that they would have expected fostering agencies to carry out a realistic assessment of the

capability of foster carers and arrive at an evidence based view of the range of ages for whom they can be approved to care.

Ms Ritchie was also uneasy about the use of blanket age range approval. She accepted that blanket age ranges were not something that should never be used but felt that they should be evidence based, and thought that they should be narrower than zero to eighteen. She pointed out that some prospective foster carers may very well have brought up children from zero to eighteen and would therefore be equipped to foster care for children in that age range, and she recognised the problems that a narrower range caused with administration and potential with the pool of foster carers. She referred to the concept of “stretching” that was used as a term to describe a placement outwith terms of the approval. On occasion there could be a justification for that because, for example, of the difference between the chronological and developmental age of a child who was perhaps chronologically older than the age a foster parent was approved for. She had never worked with a local authority using blanket age range approvals and stated she would not work for an organisation that used blanket age range policy because she was hesitant about it. She pointed out that the skills required to look after small children and the skills required to look after teenagers could be different and needed to come from either skills experience, capabilities, or competencies which would be assessed for, and she would be

looking for evidence to support a belief that people had such an ability. Her professional experience was of much narrower approval.

Considering the views expressed by the Fostering Network, BAAF, and the Care Inspectorate together with the views of Ms Maclean and Ms Ritchie I have come to the conclusion that it is the matching process that is crucial in this area and not the use of blanket age range approvals *per se*. There do seem to me to be valid reasons why blanket age range approvals may be used – they appear to be administratively less bureaucratic, they appear to potentially at least increase the pool of foster carers who are in short supply, and accordingly increase placement availability and choice. It is critical however that fostering agencies do make a realistic assessment of the capabilities and skills of foster carers, to form a view of the ages, both chronologically and developmentally, of children for whom they could care, based on evidence. The matching process is crucial to this and clearly requires to be robustly applied to ensure that carers are not approved for children where they do not have the necessary skills to care for them, and children are not sent to carers who cannot offer them appropriate care.

Given the discussion above, the use of blanket age range approvals does not appear to me to be a defect in a system of working which contributed to the death or any accident resulting in the death but rather a system which requires matching to be a robust process. It is not the system which is the

defect, rather that problems can arise when those working within the system do not use sufficient rigour and care when operating it. Although I have made a finding under Section 6(1)(c), I have therefore made no finding under Section 6(1)(d) in this regard. The use of blanket age range approvals has advantages and disadvantages and the latter can be avoided by proper application of the matching process.

The use of stated age preferences however can cause confusion. It is not always clear whose preference is being expressed and whether it is that of the prospective carers, the assessor, or the Panel. The Significant Case Review recommended to FCAS the system which was in use of an unrestricted age range with a stated preference should be changed to more accurately reflect the agency's professional assessment of the foster carer's strengths and abilities with regard to particular ages of children and they felt that this was an especially important matter for early placements of newly approved foster carers. I entirely agree with that view. FCAS I understand have discontinued the use of preferences. Where it is still in use it is my recommendation that such use cease and that the matching process be applied rigorously, within the age range approval specified, to ensure that the strengths and abilities of the prospective foster carers are matched with the needs and ages of children so that the best possible care is given by the appropriate carer of the particular child in question.

## **Recommendations**

[44] I consider that it may be helpful if I set out the recommendations, made by the authors of The Significant Case Review to GCC and FCAS. I was satisfied from the evidence which I heard that these have been taken on board and implemented both by GCC and largely by FCAS where they were not already in place. These agencies have reviewed practices and policies, and do so in an ongoing process which is kept under review. The evidence in this Inquiry formed the basis for these recommendations, which appear to me to be both valid and appropriate given the evidence which I heard. The specific issues raised and discussed in this Inquiry inevitably overlapped with them, particularly in relation to the approval of specific age ranges and blanket age range approval, and training, which have also been dealt with herein. Other matters dealt with in these recommendations were discussed in this inquiry, but were largely peripheral to those considered under Section 6(1)(e) above, and it has not been felt necessary, given these recommendations, to deal with them separately.

[45] This Determination may however be scrutinised by other similar bodies, and the recommendations may be of assistance to them, as stated by the SCR Team, as “having the potential for policy and practice learning across Glasgow’s Child Protection Systems and for other agencies commissioned to provide child care services”.

[46] The recommendations to GCC were as follows:-

### **Action 1**

All other agencies, with the exception of Police Scotland, should review existing staff supervision, support policies and systems to ensure that structured reflective

supervision is embedded, especially in the management of complex cases. Police Scotland has their own arrangements in place.

#### **Action 2**

All agencies should ensure that the use of inter-agency and single agency chronologies and case histories is embedded in policy and practice and that sufficient importance is given to reflective consideration of chronologies and case histories in case planning and risk assessment. This should have specific emphasis at the point of transfer to another worker or system.

#### **Action 3**

During the period under review there were significant changes within both organisations, the local authority was subject to change in organisational and staffing structures and the independent foster care organisation was subject to change associated with rapid growth. In both organisations, there was also a relatively high turnover of front line staff and first line managers in the particular offices involved. This can impact on the continuity of services, supervision and case management. GCC Social Work Services and Core Assets (FCAS) need to ensure that robust systems are in place to ensure there is continuity of high quality services for vulnerable children and that there are sound processes for the transfer of information between “old and new” systems and workers.

#### **Action 4**

The Inter-agency Guidance on working with Hostile and Uncooperative Families should be reviewed and refreshed, with particular reference to what should be done when local options have failed to bring sufficient control to the management of a case. The review should also include agency policies on reporting violent incidents. Specific consideration also needs to be given to managing aggression and threats directed to foster carers.

#### **Action 5**

GCC Social Work Services should put in place a system to monitor all permanence recommendations and decisions and where necessary, put practical measures in place to ensure child centred and timely outcomes.

#### **Action 6**

GCC Social Work Services should always agree and sign placement agreements with independent fostering agencies, where possible prior to placement. They should also always provide copies of LAAC reviews and other relevant documents to the fostering agency. When approving foster carers and matching children with them, greater weight should be given to the foster carers’ previous experiences, particularly with regard to the age range of children to be placed.

#### **Action 7**

All agencies should review practice to ensure that, where children’s usually good behaviour is not in keeping with their experiences, carers, foster agency, health and

local authority staff are alert to potential risks and have opportunities to discuss them. The focus for these reflective discussions should be any underlying reasons and possible responses.

#### **Action 8**

All agencies directly involved in making and supporting foster placements should review how their systems, services and decisions can be more conducive to developing children's attachments and resilience and to mitigating trauma.

#### **Action 9**

GCC Social Work Services and Children's Hearings Scotland should consider how supervised, restricted or terminated contact can be managed appropriately in the context of children having access to social networking sites.

[47] The recommendations made under separate heading to FCAS by the Significant Case Review were as follows:-

1. Should an unusual staffing situation occur such as that in Hamilton 2010/2011 the organisation needs to do more to mitigate the effects of high staff turnover; promotion and sickness it should ensure that the remaining staff are fully supported, have manageable workloads and that all relevant records and available background reports are read before a foster placement is made.
2. The perceptiveness and the thoroughness of the analytical aspects of carer assessment and the required experience of assessors should be reviewed.
3. The current system on unrestricted age ranges with a stated preference needs changing to more accurately reflect the agency's professional assessment of the foster carer's strengths and abilities with regard to particular ages of children. This is especially important for early placements of newly approved foster carers.

4. Foster Panels need to ensure they minute their discussions, as well as any recommendations made, concerning all the recommendations and suggestions made in the reports they receive. If suggestions continue to be made by Panels it would be helpful if the intended method of taking them forward was also minuted. ADM must make and record decisions on all recommendations made by the Panel and should also comment on suggestion. Carer profiles must fully reflect these actions and decisions.
5. There should be better recording of matching process giving full explanations both on matches made and for those not made.
6. Timing of, consistency of carers and introductions to respite placements should be made more child centred. Reports of respite placement should always be kept on the main carer's record as well as the respite carer's record decisions and actions.
7. Staff and carer training needs should be reviewed in light of this report. In particular, all carers approved to take children in middle childhood or adolescence should receive CPI training prior to taking first placement.
8. Consideration should be given to how FCAS can further develop its systems and services to be more conducive to developing children's attachments and resilience and to mitigating trauma.
9. The support and training needs of carers who are not the main carers need to be reviewed. More regular ways need to be found to elicit their views and to ensure their involvement.

10. It should ensure that carers have appropriate technical support and training in order that foster children's use of mobile phones, computers and other technological devices is made as safe as possible.

[48] I am similarly satisfied in respect of the recommendations made to FCAS that appropriate attention has been given by them to these recommendations and they have behaved responsibly and responded appropriately to them, taking on board and acting on the recommendations made with the exception of a part of recommendation 7 which they have made it clear they disagree with. I have made my own recommendations which to an extent mirror those made by the Significant Case Review in this regard.

[49] Against that background and taking account of the changes in practice which I am advised have already taken place I make the following recommendations:-

1. Staff and carer training needs should be reviewed to ensure that all first time foster carers approved to take children in middle childhood or adolescence should receive Crisis Prevention and Intervention training prior to taking up their first placement.
2. Prospective foster carers when being asked to consider a placement should be given as much information as possible in writing, in a digestible and understandable form, about the child or children who are the subject of the placement to inform their decision as to whether or not to accept the placement offered. Full and detailed notes should be kept of any meetings

that occur when the placement is offered to prospective foster carers when such information is passed on.

3. The system of using stated preferences within unrestricted age ranges should be discontinued. Emphasis should instead be given to foster carers' strengths and abilities and any perceived weaknesses with regard to their ability to care for the child or children to be placed with them. This is especially important for newly approved foster carers.

### **Conclusion**

[50] The tragic circumstances of the death of Dawn McKenzie which precipitated this Inquiry are, so far as I have been advised in evidence, unique amongst foster carers. From the evidence of Dr Eleanor Kerr it is clear that more is being learned about the damage that a traumatic upbringing can have on children, particularly in the early years of their development, and the lasting effect that that can have on them. From all the evidence that I heard no one could have predicted that child D would have acted in the way in which he did, and no one could have predicted the tragic consequences for a dedicated and caring foster carer such as Dawn McKenzie. As a result of those events which took place over four years ago there is no doubt that lessons have already been learned and changes in practice have occurred. There was also evidence which I accepted that changes in practice were in any event ongoing and evolving. It was not foreseen nor was it foreseeable that child D would take the life of the person who was caring for him, but now that that has happened clearly it is an eventuality which has to be considered by those involved in caring for children in a fostering environment. It is to be sincerely hoped that such an event never

reoccurs, and that the appropriate agencies are now alive to the tragic possibilities and will do all that can be done to ensure that that is so. It is clear that both GCC and FCAS take their responsibilities extremely seriously and they have taken on board changes needed to practice and to promote the safety of foster carers and children in care.

[51] There are areas where justified criticism was made, both by Mr McKenzie, and by expert witnesses, of the actings and omissions of some of those involved in the circumstances leading up to the tragic death of Mrs McKenzie. It is recognised that while those involved do not operate in an ideal world, and there was and still is a shortage of foster carers to choose from, nonetheless high standards require to be maintained in the placing and supporting of children and their carers, in a fostering environment.

[52] I am grateful in particular to the Crown for the very considerable amount of work that was done in preparing this Inquiry and the submissions after it, and I am also grateful to the representatives of all parties for the co-operative and expeditious approach taken to the evidence and for the courtesy and consideration shown throughout to the witnesses and to the members of the McKenzie Family present. I also wish to express my appreciation of the dignity and dedication of the McKenzie Family many of whom sat throughout this Inquiry

to listen to the evidence, though it must have been extremely difficult for them at times to do so.

Sheriff David M Bicket

Sheriff of South Strathclyde, Dumfries and Galloway at Hamilton.

7<sup>th</sup> August, 2015