SPSO decision report

Case: **202106196, Glasgow City Health and Social Care Partnership**
Sector: Health and Social Care
Subject: Adoption / fostering
Decision: upheld, recommendations

Summary

C and B complained about the support that they had received as foster carers from the partnership. C and B told us that they had been foster carers to two young people for a number of years. Following a significant incident in the fostering placement, social work services had taken the decision to remove both young people from their care. Following the end of the placement, C and B complained to the partnership about the adequacy of support and intervention offered to both them, and the young people, by social work services during the placement, the decision to remove both young people from their care and the lack of transition planning.

In response to C and B's concerns the partnership concluded that a reasonable level of support had been offered to them during the placement. They said that the decision to end the placement had not been taken lightly, and staff had made a professional assessment in the young people's best interests. They apologised for the delay in convening a disruption meeting, citing a number of mitigating factors, including operational constraints and government restrictions.

We took independent advice from a social worker. We found that, in the weeks prior to the incident, the partnership failed to follow their Placement Support Practice Guidance, specifically a Placement Support meeting was not convened to explore how the placement could be supported and maintained. We found that following the incident, the partnership's communication and support to the family was not robust or proportionate, and an appropriate debrief had not taken place, including an urgent risk assessment. We found that there was a lack of young people involvement in decisions about their future care planning. The partnership did not complete appropriate transitioning planning or risk assessment to assist the young people, and the foster carers, with the immediate impact of the end of placement, including seeking the young people's views in respect of their onward communication / contact with their foster carers. We also found that there was an unreasonable delay by the partnership to convene a disruption meeting following the placement ending and inconsistencies in their policies and practice guidance in respect of timescales for a meeting. Therefore, we upheld C and B's complaints.

Recommendations

What we asked the organisation to do in this case
Apologise to C and B for failing to convene a disruption meeting in a timely manner. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
Apologise to C and B for failing to provide an appropriate level of support to them as fosters carers. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Where a long-term fostering placement is at risk of breaking down, a Placement Support meeting should be convened as soon as possible to explore how the placement can be supported and maintained.
- Ensure that there is clarity across all of the partnership's policies and practice guidance in respect of

timescales to convene a disruption meeting so that there are no anomalies that remain for practitioners, foster carers and service users. When there are genuine reasons for delay in adhering to these timescales then this should be consistently conveyed to the foster carers and partners to the child/ young person's plan.

- The child / young person’s views should be sought and clearly recorded in decision-making about their care plan.
- Where a long-term fostering placement breaks down, a robust transition plan with input from the foster carers and the children / young people affected should be formulated to assist with the immediate impact of the end of the placement.
- Where a significant incident has occurred in a fostering placement, appropriate support should be offered to the family and a formal debrief meeting facilitated with the family as soon after the event as safe to do so. This should include risk assessment and care planning in light of any risk identified. All views of the incident should be considered and recorded with any immediate and long-term actions being transparent and recorded in case notes.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.