

Thematic analysis of serious safeguarding practice reviews of children subjected to Special Guardianship Order (SGO): Qualitative document analysis

Molly Hammad¹✉, Lauren Miller¹, Joanna Garstang¹✉

¹ School of Nursing and Midwifery, University of Birmingham, Birmingham, UK

✉ m.hammad1@nhs.net; j.garstang@bham.ac.uk

Abstract

Background: Special Guardianship Orders (SGOs) legally transfer parental responsibilities to a special guardian who will be responsible for the welfare and needs of the child/children. SGOs are commonly successful and stable for children. Known underlying risk factors for the termination of SGOs are the child's age when the order was created, the number of prior care placements, and SG's relationship with the child before the order. However, there are currently no available statistics on safeguarding concerns arising after SGOs are granted. Serious Case Reviews (SCRs) and Local Child Safeguarding Practice Reviews (LCSPRs) were selected from the National Case Review Repository and were analysed using thematic analysis. These reviews examine how agencies collaborated to safeguard children who experienced significant harm, abuse, neglect or death. **Aim:** The study aims to thematically analyse SCRs and LCSPRs relating to serious safeguarding concerns post-SGO. **Methods:** Eleven SCRs and LCSPRs, focused on fifteen children with SGOs, were thematically analysed. The data was coded using NVivo V.12 software. **Results:** Known perpetrators of child abuse were the special guardians, the partners of special guardians, and the parents of the child. The themes were: Failure to Risk Assess, Court Decisions, 'The Family is Better' View, the Child's Voice Not Heard, Absence of Support, Inadequate Support, Poor relationships between Special Guardians and Professionals, and Special Guardians' struggle to maintain the SGO. The eight themes are spread across 'Professionals' Treatment of Children and Special Guardians' and 'Special Guardians' Actions' to distinguish themes relating to professionals' or special guardians' actions. **Conclusions:** The research highlights insufficient suitability assessments of special guardians, stemming from time constraints on care proceedings and the assumption that placement with the relatives was best for the child. Absent support plans and insufficient fulfilment of supervision orders contributed to special guardians struggles in supporting their child. Improvements needed include extending the 26-week assessment deadline, establishing robust support plans, and enhancing advocacy for children's voices in their care plans.

Introduction

Special Guardianship Orders (SGO) transfer parental responsibility for children from their birth parents to special guardians, who will make daily decisions regarding the child's welfare (Department of Education, 2017). Before the introduction of SGOs in 2005, children who were legally removed from their parents were mainly placed into foster care or were adopted. Foster care does not possess the legal permanence that SGOs have, leading to feelings of not belonging among children (Biehal, 2014; Wade et al., 2014). The White Paper on adoption (Cabinet Office, 2000) called for special guardians to be an alternative care route for children unsuitable for adoption, such as older children, those with cultural or religious restrictions against adoption, and children being cared for by kin. SGOs and foster care provide protection and care for children; however, unlike adoption, SGOs facilitate continued contact with birth parents, as children are typically placed with family members or close family friends (White Paper, 2000; Thompson, 2019; Woodward et al., 2021). The White Paper led to the inclusion of Special Guardians in the Adoption and Children Act of 2002, and SGOs became effective in 2005 (Department of Education, 2017).

Between 2006 and 2011, 5,921 SGOs were approved, with a disruption rate of about 2%, meaning that only a small number of these arrangements (approximately 118 cases) ended early or did not work out as intended. By 2017, the total number of approved SGOs had risen to 21,504, with a disruption rate nearing 6% (Selwyn et al., 2014; Harwin et al., 2019a). Wade et al. (2014) found that disruption was strongly associated with children who had experienced more than three previous foster placements, had been living with kin before the order, and were older at the time the order was established. Specifically, children aged 5 to 10 had a 6% termination probability within five years, compared to a 4.2% chance for those aged 1 to 4 (Harwin et al., 2019b). Additionally, 11% of SGOs had supervision orders to enable the local authorities to advise and assist the child and family; however, SGOs with supervision orders had an increased chance of placement instability (Harwin et al., 2019). Supervision orders can be made alongside SGOs when a child requires further supervision by the local authority for one to three years after SGOs are granted because continuing support is necessary for the child or family (Ryan et al., 2021). Reasons for supervision orders are keeping local authorities accountable in providing support, older children not wanting the care order to be created, or when identified risks could affect the order's success (Ryan et al., 2021).

SCRs and LCSPRs

Serious Case Reviews (SCRs) examine how agencies work together to safeguard children who have suffered significant harm from abuse or neglect, including death (Children's Act, 2004). The function of SCRs was to examine how missed chances to record, understand and share critical information across agencies caused severe compromises to children's safety and well-being (Department for Education, 2017).

SCRs identify improvements in safeguarding and establish risk prevention through beneficial teamwork among professionals rather than assigning blame for failures. (Munro, 2010; Department of Education, 2018; Dickens et al., 2022). SCRs were renamed as Local Child Safeguarding Practice Reviews (LCSPR) in 2018/2019, but the purpose of identifying and addressing new and persistent issues in child safeguarding has remained (HM Government, 2018; Child Safeguarding Practice Review Panel, 2022).

Definition and consequences of child abuse

Child abuse, encompassing physical, emotional, sexual abuse, and neglect, can be perpetrated either as isolated incidents or continuously by adults or other children against individuals under 18 years of age (World Health Organization (WHO), 2019). This study adopts the WHO definition of child abuse.

The profound consequences of abuse on children's emotional, physical, and social development are well-documented (Stanley, 2011; Nemeroff, 2016; Barlow et al., 2023). Exposure to childhood abuse can disrupt attachment development and neurological progress of social-emotional processes in the brain, affecting stress management and emotional regulation (Dahake et al., 2018; Barlow et al., 2023). The impacts of child abuse have been shown to worsen health outcomes in adulthood. Stanley's (2011) meta-review found adults with previous childhood abuse trauma had elevated inflammation markers and the development of physiological problems such as gastrointestinal disorders, chronic pain, and cardiovascular diseases. Morbidities increase healthcare costs and strain resources across primary, secondary, and tertiary services, though many could have been partially prevented (Soley-Bori et al., 2021). Implementing preventive measures against child abuse is crucial to mitigating the development of harmful diseases and adverse health conditions associated with abuse.

No data exists on serious safeguarding concerns after SGOs have been granted. This analysis of SGO safeguarding reviews will reveal new concerns within SGOs and identify improvements to professionals' safeguarding efforts. This research addresses this gap by examining SCRs and LCSPRs on children subjected to SGOs. This project selected reviews from the National Case Review Repository as it is the only database for SCRs and LCSPRs (NSPCC Learning, 2022).

Research Justification

The rationale for this project is the limited research on safeguarding concerns relating to SGOs. Identifying factors that lead to abuse and neglect can inform future social care initiatives, helping to safeguard these vulnerable children more effectively.

Aims and Objectives

This project aims to identify areas for improving the safeguarding practice of SGOs and to enhance professionals' understanding and practice of supporting and protecting special guardians and children by thematic analysis of SCRs and LCSPRs.

Objectives:

- Obtain SCRs and LCSPRs relating to children on SGO from the NSPCC's National Case Review Repository.
- Screen and thematically analyse the safeguarding issues relating to SGOs.
- Identify factors that lead to safeguarding issues within SGOs to identify potential improvements in practice.

Methods

Study Design

This study used qualitative document analysis and interpreted the data from the reviews using thematic analysis. Document analysis, focusing on government documents, was integral to this study of local UK government reports. This design enables sensitive reports, such as reviews on the National Case Review Repository, to be analysed without intrusion and is often free (NSPCC Learning, 2022). Document analysis can only reveal what has been captured within the data collection (Ernst, 2019).

Sample

Data were gathered from SCRs and LCSPRs, published from 2005, the date SGOs were introduced into UK law, to 2024. The reviews were extracted from the National Case Review Repository, the database for SCRs and LCSPRs (NSPCC Learning, 2022). The repository was searched using the following search terms: ‘Special Guardianship Orders’, ‘Special Guardianship Order’ and ‘SGO’.

One hundred and four reviews were identified. Eighty-six reviews were excluded because they were not about children and young people who were subjected to SGOs. Seven reviews were further excluded because the abuse occurred after the termination of the SGO. In total, eleven reviews were included for analysis.

Data Collection and Analysis

NVIVO V.12 software (QSR International Pty Ltd., 2018) was employed for the coding as NVIVO has been used in research on SCRs and LCSPRs (Garstang et al., 2023). An initial read of the 11 reviews occurred before data collection. Codes were created separately amongst the researchers on the second read-through. This separation allowed ideas about initial codes to form without the influence of the other researcher. Guidance for data collection aimed to identify factors contributing to the safeguarding issues that occurred within SGOs, thereby enhancing professionals’ practices concerning special guardians and children.

Following Braun and Clarke’s (2006) framework, researchers are able to focus equally on initial read-throughs, data collection, and data analysis. Defining each code allowed differences and similarities of codes to become apparent, enabling the organisation of potential themes. Themes were developed to interpret the majority of the data set, with transparent accounts provided for each theme to avoid blending. The researchers independently reviewed the themes to reduce bias. Thematic analysis can be good, but if the guidance is not followed correctly, themes may be broad, overlapping, and lack consistency (Braun and Clarke, 2006; Nowell et al., 2017; Kiger and Varpio, 2020). Defining themes ensured clarity and prevented overlap. A theme map was created to demonstrate the vulnerabilities in professionals’ safeguarding practices and the barriers preventing special guardians and children from receiving effective help and support.

MH and LM, final-year student nurses at the University of Birmingham, conducted the initial reading, coding, and theme-building. Our supervisor, Joanna Garstang, advised and counselled us throughout the study.

Ethics

This study did not require ethical approval because the reviews were publicly available.

Results

Eleven SCRs were included in this review, and fifteen children with SGOs were examined, see Table 1. Twenty-five children, including the fifteen children with SGOs, were mentioned in the reviews. Five children had been physically abused, two of whom died as a result. Four children were victims of sexual abuse, while two faced neglect. Additionally, two children were criminally exploited, one experienced emotional abuse, and four children endured more than one type of abuse. The ages ranged from 1 and 16 years old. The genders of the children were not always known, but six females and five males were identified. Three children were identified as white British, two as Black Caribbean, and one as both white British and Black

Table 1. Details of each review

Review number	Local Authority of the SCR / LCSPR	Details of the children with SGOs (name, age, ethnicity, gender)	No. children mentioned in reviews	Type of abuse	The abuser	Who was the Special Guardian?
1	Devonshire Safeguarding Child Board	Bonnie 2 years old White British Female	1	Sexual Abuse	Maternal Grandfather	Maternal Grandmother
2	Oxfordshire Safeguarding Children Board	Child A and B <5 Years Old Ethnicity not known Gender not known	3	Physical Abuse	Mr K, Distant Uncle	Mr K and Ms. L, Distant Uncle and Aunt
3	Surrey Safeguarding Children Board	Child G (Ages not known) White British Female	4	Sexual Abuse	Great Maternal Uncle	Great Maternal Uncle and Aunt
4	Lewisham's and Harrow's Safeguarding Children's Board	Child LH 4 years old Black Caribbean Male	2	Physical Abuse	Maternal Aunt	Maternal Aunt
5	Unnamed Local Safeguarding Board	Child PS (Age not known) Ethnicity not known Male	1	Physical Abuse/ Child Exploitation	Relative of a staff member at the care home	Grandparents
6	Berkshire West Safeguarding Children Partnership	David 16 Years Old Black Male	1	Child Exploitation	Unknown	Two Adult Family Members
7	Northumberland Safeguarding Children Board	Family M (Ages not known) Ethnicity not known 1 female and 1 male. Other two are not known	4	Sexual Abuse	Family relation not specified	Relation not specified

Review number	Local Authority of the SCR / LCSPR	Details of the children with SGOs (name, age, ethnicity, gender)	No. children mentioned in reviews	Type of abuse	The abuser	Who was the Special Guardian?
8	South Tees Safeguarding Children Partnership	Fred 16 years old Ethnicity not known Male	1	Neglect	Stepfather and Mother	Maternal Grandparents
9	Birmingham Safeguarding Children Board	Lilly <1 year old White British Female	1	Physical Abuse/ Died	Partner of the SG	Family Friend
10	Gloucestershire Safeguarding Children Board	Megan 6 years old Ethnicity not known Female	2	Sexual Abuse/ Neglect/ Emotional Abuse	Maternal Grandfather, Maternal Grandmother, and father	Grandmother
11	Birmingham Safeguarding Children Board	Shi-Anne <1 year old White British /Black Caribbean Female	5	Physical Abuse/ Died	Distant relative of the father (Kandyce)	Distant relative of the father (Kandyce)

Caribbean; the remaining children were not specified. Preparators were identified in nine reviews: six males (father, stepfather, partners of special guardian, grandfather, grand uncle, distant relative) and three females (mother, grandmother, aunt).

Themes

The themes identify factors that directed children towards significant harm and abuse (see Figure 1 for relationships between subthemes). The themes are discussed in order of timeline, from SGO assessment through to post-SGO approval, highlighting failures in recording and monitoring that jeopardised the safety of these children. The reviews are referenced by their corresponding number in the “Review No.” column (see Table 1) in the results section.

Professionals’ Treatment of Children and Special Guardians

Failures to Assess Risks

Failures to Assess Risks outlines the low rigour of risk assessments of special guardians. This theme was present in all reviews.

Five reviews demonstrated poor professional exploration in risk assessments of special guardians. Previous sexual abuse evidence against special guardian (of Child G) ‘should have produced an analysis reflecting far higher risk than was apparent in the SGO report’. (Case 3). ‘No work was carried out to try and change her behaviour to reduce the risks to her children’ when the social worker identified evidence of previous child abuse committed by special guardian (Case 4). Services did not adequately challenge special guardians’ suitability to care for and protect these children despite evidence being known to services that special guardians had previously harmed other children.

Concerningly, seven reviews found that professionals did not explore risks post-assessment despite evidence of abuse or neglect. Child PS had signs of being exploited while working at a car wash facility, the same place he was assaulted, but ‘it would appear that at no point was Criminal or Sexual Exploitation considered by services’. (Case 5). When bruises were located on Lilly, ‘the nursery held no discussion with the Children’s Advisory and Support Service (CASS) for advice, as they took the special guardian’s words at face value’. (Case 9). Consequently, professionals identified abuse or harm but failed to adequately assess and document special guardians’ abilities to care for and protect these children.

Court Decisions

In eight reviews, key information required by courts to determine special guardians’ suitability was absent when SGOs were approved. The Courts approved orders without waiting for necessary information, such as DBS checks and medical reports, that would determine the special guardian’s ability to safeguard the child (Case 3). The author of Case 4 commented that ‘Courts would be prepared to make such orders not infrequently without the results of some checks being received’. Courts were noted as having a ‘lower threshold for approving special guardians, focusing on a ‘good enough’ here and now’ rather than evaluating historical risks concerning the individual’s suitability to become a special guardian (Case 9).

The Family is Better View

The theme illustrates that professionals assumed special guardians would work in the child’s best interest and would not consistently assess special guardians’ ability to safeguard these children when approving SGOs. ‘The courts favoured the making of special guardianship orders, if possible, to maintain care within

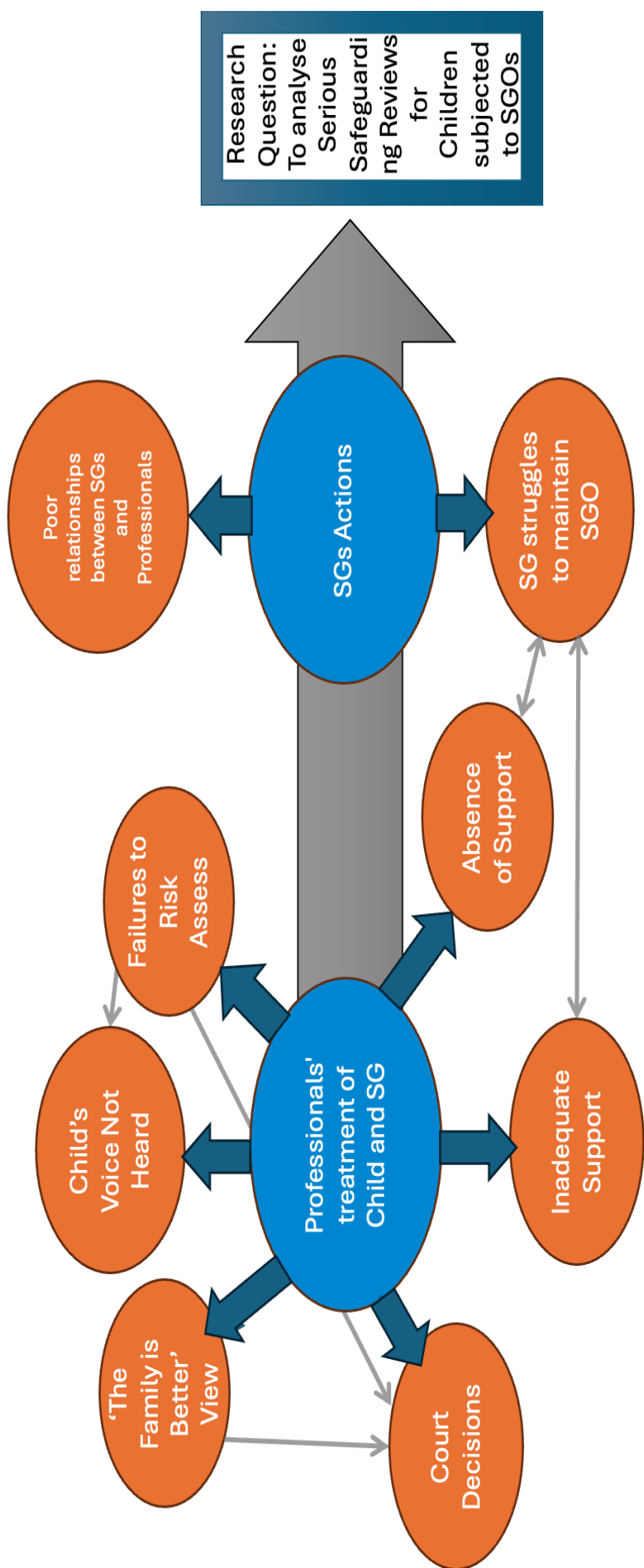


Figure 1: Relationship between the subthemes and overarching themes. Note: Blue arrows link overarching themes to subthemes. Grey arrows indicate relationships between subthemes.

the extended family' (Case 4). 'Family and friend's assessments were decisions driven by a focus on the positive benefits of placing children within the family'. (Case 7).

Child's Voice Not Heard

This theme, evident across all reviews, demonstrates that professionals did not encourage children to express their views in care proceedings and subsequent care plans. 'It does not seem that the Advocacy Service was ever engaged to help PS present his views in any of the many forums that were meeting to discuss his future'. (Case 5). 'Children's views are not taken on board in the decision making, and often they have not met'. (Case 10).

Eight reviews showed children notified professionals about being abused, but professionals failed to conduct proper investigations into these concerns. When Child G reported being sexually abused by her special guardian, there was 'little evidence of planning and preparation for the interview and in particular, no consideration was given to whether Child G should have had an intermediary'. (Case 3). Child G's eventual disclosure outside interview conditions meant her story could not be evidence in court. Thereby, Child G's voice was not heard within the proper context.

Absence of Support

There were incidents of insufficient support for special guardians after the children came into their care. Special guardians support children with Adverse Childhood Experiences (ACEs), often without proper training and professional support. Despite the absence of formal training, special guardians have provided substantial emotional and practical assistance to these children. However, mental health support that did not come to fruition left special guardians managing the children's mental health and well-being on their own. Despite professionals offering therapy, 'Child G did not receive specific therapeutic support during this period' because Children's Social Care did not pursue this support (Case 3).

Only some special guardians were supported by universal community services due to the service's unawareness of these children.

Systemic failure to ensure that Lilly was integrated into community health services, specifically health visiting, and to ensure that she was identified as a child with a challenging neo-natal history, cared for within an SGO, and therefore entitled to Universal Plus services. (Case 9)

On the other hand, some special guardians did not pursue the support offered, as demonstrated in Child G's and Megan's case. 'Education staff report that support was being offered to Mr and Mrs A from the school and wasn't always taken up'. (Case 3). The explanation in Case 10 may explain the special guardian's lack of willingness to access support: 'There is no statutory duty for the special guardian to accept or comply with training or to accept support as they have parental responsibility and not the Local Authority'. (Case 10).

Inadequate Support

Discrepancies were identified between planned and actual support plans provided in nine reviews. Supervision orders added adjacent to SGOs often were not fulfilled. 'Although the supervision of the social worker in January 2017 noted that 'visits taking place; Lilly doing well; special guardian engaged', there is no actual record of any visits or of any meetings after the SGO was made'. (Case 9). Some SGO plans did not include support, potentially because professionals primarily determined support. For example, professionals did not consider the emotional support Child LH would require within his support plan.

The SGO support plan was mainly focused on financial support and contact arrangements for

the family. Discussions during the course of the assessment had been had about training for life story work for Ms X and possibly mediation for the family to improve the relationship between the two sisters. In fact, neither of these two things were included in the final SGO support plan. (Case 4)

Special guardians felt their limited knowledge of accessing support impacted how well they could care for these children. When Fred's behaviour became challenging in 2019, the social worker did not remind the special guardian of the support they could access (Case 8).

Special Guardians' Actions

Special Guardian Struggles to Maintain SGO

This theme details eight special guardians' efforts to support children. Three special guardians felt unsafe because of the risky behaviour exhibited by the children and eventually were unable to care for these children. David's criminal activities with gangs left the special guardian 'not feeling safe in her house. Alternative care was considered'. (Case 6).

Five special guardians did not seek support from their local authorities, resulting in special guardians and children appearing to cope without support when, in fact, they were not managing. One author explained this behaviour as disguised compliance where the special guardian displays 'the appearance of cooperating with services, while in fact failing to do so' (Case 9).

Furthermore, special guardians determine the level of support they want to access because 'the special guardian has parental responsibility and does not have to comply with support packages offered and are not subject to Gloucester's Children's Social Care checks...' (Case 10).

Poor Relationships between Special Guardians and Professionals

In four reviews, communication breakdowns occurred between special guardians and professionals. The special guardians' lack of involvement with the school meant teachers could not challenge the special guardian's treatment and care of Megan (10). In three reviews where special guardians were not the abusers, tensions between special guardians and professionals, specifically social workers, contributed towards personal disputes, strategy disagreements or limited communication. 'There was a lot of tension between Grandad and Social Worker due to feeling that Child had let them down during the period of the Guardianship'. (Case 5). 'The carers reported feeling frustrated and angry with these meetings as from their perspective they achieved little. This led to withdrawal of the carer's involvement in these meetings'. (Case 6).

Discussion

Eleven SCRs were examined concerning 15 children with SGOs, and eight key themes were identified: Failure to Assess Risks, Court Decisions, Family is Best View, Child's Voice Not Heard, Absence of Support, Inadequate Support, Special Guardian Struggles to maintain SGO, and Poor Relationships between Special Guardians and Professionals. All fifteen children were abused post-SGO approval, and this continued due to poor safeguarding practices. Insufficient pre-examination within SGO suitability reports misjudged special guardians' abilities to protect and care for these children. Important information was absent from suitability reports because of delays or inadequate time for preparation. This resulted in situations where individuals known to have abused children were deemed suitable as special guardians. Professionals did

not appropriately support children's disclosures of abuse. Special guardians struggled without professional support despite support plans being put in place; this contributed to delays in identifying abuse or neglect. The review highlights four areas of urgent improvement: improving the rigour of SGO assessments, ensuring comprehensive court decision-making processes, establishing ongoing support for special guardians, and strengthening mechanisms for hearing and addressing children's voices. Addressing these areas will uphold the integrity of safeguarding measures and ensure the well-being of children under SGOs.

This study found that the courts often assumed, without the necessary documentation and checks, that family placement was best. This assumption supports children's future identity and may explain the higher numbers of children placed with relatives compared to adoption (Thoburn, 2021; ADCS, 2022). Legal professionals within these reviews did not wait for pending DBS checks and had lower approval parameters for testing special guardians' suitability. Social workers are encouraged to consider the child's and family's needs while questioning the SGO's suitability but often struggle to get the necessary information on the special guardian's history, relationship with the child, and ability to manage connections with the birth family (Harwin et al., 2019a; Wilkinson & Bowyer, 2017). The 26-week deadline introduced in 2014 for finalising care assessments creates significant pressure on social workers to complete care plans. This deadline addressed and increased the completion speed of care proceedings, but this time constraint is impractical as only 61% of care orders are completed by this deadline (Broadhurst et al., 2018). Applying for extensions on care assessment is possible to ensure child welfare (S (A Child), 2014), but SGO suitability reports that were missing important information could suggest that professionals did not seek them. The completion speed of care proceedings and professionals' assumptions appear to be prioritised over the rigour of care assessments and plans.

In the reviews we analysed, professionals only sometimes conducted thorough checks on special guardians and children post-SGO approval. Children's Social Care (CSC) checks are uncommon post-SGO approval because parental responsibility transfers from the LA to special guardians (Harwin et al., 2019b). The Supervision Orders (for Lilly and Child G were unfilled by their social workers despite being legal requirements. Ryan et al. (2021) found that 53% of local authorities had clear guidance on supervision orders, and only half (56%) had systems to monitor the number of children with supervision orders. Professionals' beliefs could influence this underperformance of supervision orders that supervision orders lack authority, significance, and oversight to enable child protection practices following SGOs (Harwin et al., 2019b; Ryan et al., 2021; Public Law Working Group, 2023). Researchers who have evaluated supervision orders have recommended combining supervision orders with child protection plans to ensure that safeguarding is central to these observations (Carson, 2017; Public Law Working Group, 2023). The abuse inflicted on some of these children went undetected by authorities, potentially because CSCs were not fulfilling supervision orders. In most cases, the abuse occurred after the supervision orders had been discharged.

Special guardians reported a need for more comprehensive support plans and experienced inadequacies in the plans provided by CSCs and associated agencies. Support plans are viewed more as expectations than requirements, with only 34% of professionals consistently creating them (Roe et al., 2021). Support services were provided post care proceedings to only one-third of participants in one study of special guardians (Harwin et al., 2019b). Similarly, special guardians were less likely to seek financial aid and peer support than foster carers (Sakai et al., 2011; Lin, 2014).

Both external and internal barriers influence special guardians' engagement with support. External barriers include limited knowledge or access to services (Harwin et al., 2019a). In contrast, internal barriers encompass reluctance to seek help due to self-reliance, feeling obligated to take on the child, past negative

experiences with seeking help from Children's Social Care, or fear of the child being removed if unable to cope (Harwin et al., 2019a). Special guardians lacked time to understand their role, and the mental health of the children led to ineffective family integration (Harwin et al., 2019b; Hingley-Jones et al., 2020; Woodward, Melia & Combes, 2021). Some special guardians were suddenly transitioned to caregivers whilst dealing with the emotional toll of trauma and loss of family, which may impact special guardians' ability to develop positive and secure environments for these children. Special guardians may have limited time to assess and reflect on their own support needs within the 26-week deadline for completing care assessments (Broadhurst et al., 2018; Turner, 2018). Poor carer engagement with support has been shown to increase occurrences of neglect or abuse towards children (Harwin et al., 2019b). Insufficient supervision from social workers and limited resources for special guardians and children can contribute to family instability and lead to poorer outcomes for the children (Lin, 2014).

Across all the reviews in this study, children's voices were absent in care and child protection planning. Despite national legislation advocating the inclusion of children, children's voices are often excluded in care and child protection planning reviews (Valle et al., 2012; Care Quality Commission (CQC), 2016). Hargreaves et al. (2024) found that the age of children had only a minimal impact on their participation in their care planning. Professionals' judgments about children's capacity often determine children's involvement, meaning services do not fully consider children's wishes, feelings, and right to participation (Cossar et al., 2014; Hargreaves et al., 2024).

Professionals should include children's voices by making care planning more accessible and inclusive, especially for children with complex needs (CQC, 2016). Professionals should advocate for children in care plans to empower them to voice their opinions. Although advocates help children understand and participate in protection conferences, children's limited trust in the advocacy ability of social workers limits children's participation (Cossar et al., 2014). Furthermore, measures to empower children and subsequently protect them from child abuse, such as advocacy, are hampered by severe underfunding and increasing safeguarding demands (Bilson and Munro, 2019; Dickens et al., 2022). Establishing and maintaining strong partnerships amongst agencies, utilising electronic systems that alert authorities to vulnerable children earlier, and encouraging staff to enhance their knowledge and training of SGOs can all help to moderate these difficulties (CQC, 2016).

Implications and Recommendations

Reassessing the structure and support mechanisms of SGOs is imperative, given that these practices may inadvertently expose children to abuse. Many care assessments cannot be completed within the 26-week deadline. Therefore, this limit should be reconsidered to prioritise the welfare of children and families over procedural convenience. Supervision Orders hold the potential to review the suitability of placements and mitigate risks, but their efficacy depends on how comprehensively they are delivered. Establishing robust support plans and offering regular reviews could pre-emptively address the needs of special guardians and children before they escalate into a crisis.

Furthermore, training special guardians on their role and offering them support through the Adoption Fund and peer networks could reduce risks (Harwin et al., 2019a). Moreover, advocacy should be promoted to empower children to voice their opinions and participate in decisions that will alter their lives. Increasing social worker visits could foster collaboration and provide consistent support to special guardians and children, although families are under no legal requirement to accept these. The feasibility of such initiatives warrants further exploration, especially amidst funding constraints that severely impact the delivery of these services (Harwin et al., 2019b; MacAlister, 2022).

Strengths and Limitations

This research only considered reviews of SGOs with serious safeguarding concerns; it does not represent most SGOs offering stable homes (Wade et al., 2014; Harwin et al., 2019a). Not all children who experience severe harm, neglect or death whilst under an SGO have had an LCSPR or SCR. The quality of reviews can be variable due to their subjectivity, and therefore, some cases likely need to be discovered. Attempts to mitigate against bias were achieved through analysing and reviewing findings as a team and comparing findings with previous research.

Conclusion

This study identified key areas for improving professionals' recognition of risks and the support given to special guardians and children. Suitability assessments of special guardians were insufficient in preventing some children from being placed with unsafe special guardians. Professionals' unchecked assumptions that placement with family was in the best interest of these children compromised the thoroughness of suitable assessments. Time constraints on the completion of care proceedings may have compromised the quality of assessments. Supervision orders and support plans were often not established or fulfilled; these must be prioritised. Future evaluations of SGO assessments and court processes could identify further learning and potential improvement.

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