THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

COUNCIL
FOR DISABLED
CHILDREN

Safeguarding children with disabilities and complex health needs in residential settings

Phase 1 report

October 2022

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Foreword

Our report from phase one of this national review seeks to make sense of how and why a significant number of children with disabilities and complex needs came to suffer very serious abuse and neglect whilst living in three privately provided residential settings in the Doncaster area. It brings into sharp relief how the voices and experiences of this group of children are too often marginalised, misrecognised, and hidden from public sight.

It is profoundly shocking that, in the twenty first century, so many children who were in 'plain sight' of many public agencies could be so systematically harmed by their care givers. The Independent Inquiry into Child Sexual Abuse (IICSA)[1] has highlighted profound historical deficiencies in the safety and quality of residential care for children. This review evidences how some children continue to be failed by a system that should be caring for and protecting them.

The way in which residential care provision for children with disabilities and complex needs is commissioned, delivered and its quality overseen is extremely complicated. Indeed, it might be described as a confusing maze of expectations, roles, and responsibilities. The system of checks and balances which should have detected that things were going wrong simply did not work for these children. No one body or agency had an accurate picture of what was happening and there were unacceptable delays in the robust decision making that was required.

There are undoubtedly many committed and very skilled professionals working with this group of children and their families. However, practitioners, particularly those working in residential settings, do not have access consistently to the support and quality of leadership they need.

We have a responsibility to transform how we view and work with this group of children, strengthening their voices and ensuring they are well cared for and protected so that they can enjoy the inalienable right of every child to live in a safe environment where they can thrive and flourish.

1 IICSA ' The Residential Schools Investigation', March 2022; IICSA final report https://www.iicsa.org.uk/

Many individuals and organisations have contributed to this review. It has benefitted greatly from the work of the police officers, social workers and health professionals in Doncaster as part of Operation Lemur Alpha. Professionals from across the country have offered valuable insights about what happened. Dame Christine Lenehan, Strategic Director of the National Children's Bureau and Council for Disabled Children, has been a wise and passionate lead reviewer. Dr Susan Tranter has provided excellent and strong Panel leadership, working closely with Panel members Simon Bailey, Jenny Coles, Sally Shearer and Sarah Elliott. Michelle Sharma and Claire Watkin from the Panel Secretariat have ably supported the review. John Harris has skilfully led the production of the text of the report.

Learning from what happened to these children, phase two of our review offers the opportunity for open and robust challenge about the way we support, care for and protect children with disabilities and complex needs. We look forward in 2023 to making ambitious and bold recommendations for change and improvement.

Annie Hudson
Chair – Child Safeguarding Practice Review Panel

Introduction

This review is about the experiences of 108 children placed at the three independent residential settings operated by the Hesley Group in Doncaster. Doncaster Council initiated a complex abuse investigation in response to twelve 'whistleblowing' allegations. They referred these allegations to the Panel and we agreed that a national review was needed. The first phase of our review is an examination of what went wrong and why.

What has been uncovered is a catalogue of abuse and serious harm of some of the most vulnerable children in our society. A complex criminal investigation into what happened to these children is being progressed by South Yorkshire Police. Our view, as a Panel, is that we do not and should not wait for the outcomes of criminal investigations before we seek to learn what changes to safeguarding practice are needed. In light of the seriousness of the review's findings, and in advance of this report's publication, the Panel asked Directors of Children's Services (DCSs) and OFSTED to initiate urgent assurance action about all children placed in similar types of provision.

DCSs in every English local authority are overseeing quality and safety reviews of every child placed in similar types of provision for whom they are responsible. This is intended to provide reassurance that the setting meets the child's needs and to address any concerns that arise. These actions will enable local authorities, the Department for Education and the Panel to assess the extent to which provision is meeting the needs of these vulnerable children.

All of these children had disabilities and complex health needs; many of those placed with one of these residential settings were living far from home. All had an EHCP (Education and Health Care Plan). The children's stories exemplify how children with complex needs and disabilities too often have no power and voice in what happens to them. They (and their families) are frequently 'forgotten' and side-lined in public and professional discourse. The fact that these children lived far from their homes intensified this 'forgotten' status.

In this review we have spoken to those responsible for placing the children in residential care. It is clear that the process for commissioning a place is incredibly difficult and involves invidious choices; and once a child has a place, they rarely leave. If it is the right setting for the child then all is well but as in these cases enormous amounts of public money were being spent on care that failed to meet the child's needs and did not enable the child to thrive.

The second phase of this national review will explore the changes needed to the wider 'system' so that these most vulnerable children are helped to live better lives in a safe, loving and positive environment.

Our phase two report will be published in late spring 2023.

Dr Susan Tranter
Lead Panel Member for the Review

1. Executive summary

1.1 This report sets out the findings from phase 1 of the Child Safeguarding Practice Review Panel's review into the safeguarding of children with disabilities and complex health needs in residential settings. The phase 1 report looks in particular at the experiences of 108 children and young adults placed from 55 local authorities at Fullerton House, Wilsic Hall and Wheatley House specialist, independent, residential settings between 1 January 2018 and 21 March 2021. These settings were located in the villages of Denaby Main and Wilsic, Doncaster, and run by the Hesley Group[2].

1.2 The children placed at Hesley's children's residential settings in Doncaster functioned significantly below their chronological age and exhibited behaviour that challenges. They had been diagnosed with complex needs including: autism (82%), learning disabilities (76%), mental health difficulties such as anxiety, obsessive-compulsive disorder and bipolar disorder, and attention deficit hyperactive disorder (25%). Many of the children had profound difficulties with receptive and expressive communication, but were not supported when they displayed behaviours, signs and symptoms that were indicative of child abuse. They were among the most vulnerable children in society, yet they experienced systematic and sustained physical abuse, emotional abuse and neglect.

1.3 Our report sets out:

- what happened to the children and young adults placed in these settings
- why it happened
- urgent action to be taken by local authorities by November 2022, to provide assurance about the safety and care of children who may be residing in similar specialist settings
- wider systemic issues raised by the findings from phase 1, to be explored in depth in phase 2 and completed by spring 2023.

2 The Hesley Group provides specialist residential services for schools and further education. The children's homes and two residential schools were part of the Hesley Group provision.

Background

1.4 On 5 March 2021, the Doncaster Safeguarding Children Partnership agreed to initiate a complex abuse investigation (Operation Lemur Alpha) into the three specialist residential settings run by the Hesley Group. This was in response to information gathered following a whistleblowing referral reporting 12 allegations of abuse and concerns for children in Fullerton House, which was received by the Doncaster Children Services Trust on 26 February 2021. The alleged abuse included physical and emotional harm, cruelty towards children, significant levels of neglect and poor quality of care. OFSTED had received a number of complaints dating back to at least 2015, expressing concerns over staffing levels, staff conduct and possible abuse of the children. These complaints had prompted additional monitoring visits and an emergency inspection. Nonetheless, at the time the whistleblowing concerns were raised, both settings had been judged 'good' by OFSTED at the most recent inspection visit. In light of the concerns, OFSTED conducted emergency inspections of both settings in March 2021 and found serious and widespread shortfalls in leadership and management. Insufficient safeguarding measures were in place to ensure the safety and wellbeing of the children. As a result, the children had been exposed to serious harm and ongoing risk. Notices of suspension of the service were served for both settings. Between March and May 2021, Doncaster Children's Services focused on immediately safeguarding the 60 children and young adults who resided in the settings at the time of the whistleblowing allegations, liaising with the home local authorities of the children concerned to find suitable onward placements and ensure their safety. For some of the children and families, the transition to new placements has proved to be challenging. Doncaster Council and the 55 placing local authorities have continued to provide on-going support to the children and their families.

1.5 These matters were formally reported to the Child Safeguarding Practice Review Panel in September 2021. The Doncaster Safeguarding Children Partnership recommended that the Panel should initiate a national review given the seriousness of the issues and the number of local authority areas and agencies involved. The Panel convened a series of meetings with colleagues in Doncaster Council and other agencies to determine the scope of the national review. The Panel wrote to Nadhim Zahawi, then Secretary of State for Education, informing him of the national review in November 2021. The review was formally launched in January 2022. The terms of reference are provided in Appendix 1.

National review approach

1.6 The Panel commissioned Dame Christine Lenehan, Strategic Director at the National Children's Bureau and Director of the Council for Disabled Children, as the lead reviewer for this work. Christine brings a wealth of experience and expertise in this area and has an excellent track record in undertaking reviews about children with disabilities. The underpinning values for our review are informed by the principles of the United Nations Convention on the Rights of the Child.

1.7 Our review is being carried out in two phases and during a live criminal investigation. The ongoing criminal investigation means that the review team has not been able to meet with any of the 108 individual children or their parents. Members of the review team met some staff on a site visit but there has been no formal meeting with the Hesley Group. Nevertheless, within these constraints, we have employed a robust methodology that has enabled us to identify urgent assurance action and disseminate important national learning, without delay, while the criminal investigation concludes.

Phase 1 – The children's stories

1.8 In this phase, we consider and describe the experiences of children placed at Hesley's children's residential settings in Doncaster. This includes understanding how the children came to be placed in these settings, what happened to them, and what factors and issues may have contributed to their abuse and neglect. We identify the urgent action required across all local authorities in England to provide assurance about the safety and care of children who are placed currently in similar specialist settings.

Phase 1: key lines of enquiry

- How were children placed at Fullerton House, Wilsic Hall and Wheatley House, and what procedures and practices were in place to ensure that they were safe and well?
- How was the quality of care for each child kept under review?
- How did concerns arise and what was the quality of the response?
- Is what happened to these children reflective of practice more generally and how could the safeguarding system be improved?
- In the light of the findings, identify any urgent action required to assure the safety and care of children placed in similar specialist settings.
- Identify key issues for further exploration and the development of national recommendations in Phase 2 of the review.

1.9 The children resident in the settings were on the school roll at either Fullerton House School or Wilsic Hall School. Both schools had been assessed as 'good' by OFSTED at their most recent inspections in autumn 2018. In November 2021, the Hesley Group informed OFSTED of its decision to close the two schools. The schools were not in the scope of Operation Lemur Alpha as the whistleblowing allegations related specifically to the residential care settings rather than the schools. Therefore, the schools were not in scope in phase 1 of our review.

Operation Lemur Alpha

1.10 Operation Lemur Alpha has identified a very substantial number of incidents of abuse and neglect which are the subject of formal criminal investigation currently. The joint police and local authority investigation is ongoing and continues to identify further cases of potential abuse. It has highlighted several issues affecting the experiences of children placed at Hesley's children's residential settings in Doncaster. These include: the organisational culture and leadership, weaknesses in the supervision of children and young adults, concerns about the adequacy of staffing ratios, not hearing the voices of children, and extensive incidents of abuse and harm. Other themes relate to the effectiveness of the local authority designated officer (LADO) function and the impact of independent reviewing officers (IRO) from the placing local authorities. The findings from year 1 have been brought together in an interim investigation report, which is not in the public domain, so that the criminal investigation is not compromised.

1.11 A protocol agreed with Doncaster Council and South Yorkshire Police has enabled us to gather the necessary information and analyse the complaints recorded by OFSTED over the period of time in scope.

Impact of COVID-19

1.12 The impact of COVID-19 was an exacerbating factor but not fundamental in affecting the quality of care and support that the children and young adults experienced at Hesley's children's residential settings. It significantly affected the way that the children had contact with their families, and the visits and reviews by their social workers in the last 12 months of the review period (from March 2020 onwards), when visits took place in 'virtual' formats.

Key findings from phase 1

Finding 1

There is evidence that children placed in Hesley's children's residential settings in Doncaster experienced sustained, significant abuse and harm over an extended period of time. The voices of the children and young adults were not heard.

1.13 Evidence of the abuse and harm experienced by the children included: physical abuse and violence, neglect, emotional abuse, sexual harm, and medical needs not being met. There was also evidence that medication was misused and maladministered. Staff did not respond effectively to allegations or disclosures made by children against staff members. Incidents that indicated safeguarding risks were too often not recognised as such. There was an over-use of restraints and disproportionate use of temporary confinement. Children who had profound difficulties with receptive and expressive communication received little support to participate in review meetings or report the abuse they had experienced.

1.14 Given the scale of abuse and harm uncovered at Hesley's children's residential settings in Doncaster, we have initiated urgent action, through all Directors of Children's Services, to ensure that all local authorities have an up to date view about the progress, care and safety of children with disabilities and complex health needs from their area who are currently placed in residential special schools registered as children's homes (see urgent action 1 below).

1.15 Respect for children's views is a key principle of the United Nations Convention on the Rights of the Child[3], giving every child the right to express their views on matters that affect them, and for those views to be taken into consideration. In phase 2 we will look at what needs to happen to ensure the voices of children with complex needs and disabilities are listened to and heard. Areas of focus will include: developing the skills of the workforce to enable children's communication, empowering parents to 'speak on behalf of the child' when they have concerns about their safety and developing a framework for advocacy services for children with complex needs.

Finding 2

Placement far from home increased the children's vulnerability.

1.16 Professionals contributing to the review reported major difficulties in securing long-term placements for children with complex needs and behaviour that challenges. The limited range of options available for families and professionals meant that in practice, a placement some considerable way from a child's home local authority was seen as the only viable option. The average distance from home for the 108 children placed at Hesley's children's residential settings in Doncaster was 95 miles. In phase 2 of the review we will examine ways to improve the operation of the placements market to ensure that children can access provision that meets their needs locally.

Finding 3

Some children were placed at the settings inappropriately.

1.17 Effective decision making processes by the local authority and other partner agencies are vital for children when the suitability of a residential setting to meet a child's needs is being considered. Our analysis found that inadequate and insufficient consideration was given to the education, health and care needs of the child and the impact that their placement would have on the other children. This led to a significant increase in anxiety, traumatic episodes and behaviour that challenges. Best practice in decision making requires further consideration and this will be addressed in phase 2 of the review.

3 United Nations Convention on the Rights of the Child, Article 11.

Finding 4

Leadership and management in the three settings were inadequate and failed to meet statutory requirements, resulting in a culture of poor practice and misconduct by care staff.

1.18 Documented policies to promote a safeguarding culture and ethos in the three settings were not implemented in practice. In reality, a culture of abuse and harm prevailed, with ineffective management action to challenge it. As the settings offered all-encompassing packages of support for the children, there was little input from external agencies to challenge ways of working. Where staff within the settings did raise concerns, they were either not considered or were minimised by senior managers.

1.19 The impact of ineffective leadership and management was reflected in the poor practice experienced by the children in the settings. Practitioners often diverged from support plans that had been agreed by the local authorities placing the children at Hesley's children's residential settings. A key area of focus for Phase 2 will be the changes required in terms of professional development and support to ensure that residential settings are led by appropriately qualified leaders with the skills and experience to promote and maintain the quality of safety and care.

Finding 5

High rates of staff turnover and vacancies, as well as poor-quality training, support and supervision, were significant factors affecting the children's quality of care.

1.20 Over the three-year period in scope, the staff turnover at Hesley's children's residential settings in Doncaster was 38.6%. Children and young adults in the settings were not provided with the appropriate ratios of staff and the level of supervision to meet their needs. Staff received limited induction, and some did not have sufficient knowledge or training to recognise the signs that children were at risk and how to respond. In phase 2 we will draw on the learning from OFSTED's urgent review of workforce sufficiency and quality (urgent action 3 below) to inform our recommendations for what needs to be done to build a committed workforce with the skills and knowledge to understand and respond to children with complex needs and disabilities in residential settings.

Finding 6

The settings demonstrated significant weaknesses in their compliance with statutory reporting requirements under the Children's Homes (England) Regulations 2015. Inaccurate and inconsistent record keeping and statutory reporting by the settings meant that OFSTED and the placing local authorities often had a false picture of the care, safety and progress of the children.

1.21 Absent or incomplete reporting by the settings obscured serious incidents and concerns, meaning that OFSTED and the local authorities did not have an up to date and accurate view about what life was like for the children.

Finding 7

Quality assurance processes in the local authorities placing children at the settings were inconsistent and did not enable them to have a full picture of the children's progress, welfare and safety.

1.22 Local authorities and partner agencies placing children at the settings put great reliance on the reports provided by the settings, and did not sufficiently challenge them. There was a lack of triangulation with other independent sources of information about the children.

1.23 The degree of proactivity from local authorities in undertaking statutory visits to the children had a significant impact on their safeguarding. There were some good examples of local authorities increasing the frequency of visits in response to observed concerns, but overall the practice was variable. COVID-19 significantly disrupted the capacity and formats for visits.

1.24 In response to findings 6 and 7, in phase 2 we will examine the changes required in the monitoring and oversight arrangements for providers and placing local authorities to ensure that children are safe and not at risk.

Finding 8

There were major failings in operation of the LADO function, resulting in allegations about the conduct of staff in the residential settings not being investigated to a satisfactory standard.

1.25 The LADO function in Doncaster was not effective in bringing together information from a range of sources to analyse the pattern of safeguarding concerns about staff at Hesley's children's residential settings. As a result, children were not adequately safeguarded. Before our national review had been commissioned and as soon as these failings came to light through the investigation, Doncaster Council commissioned an independent investigation of the LADO function hosted by DCST. The investigation provided assurance in relation to the current effectiveness of the LADO function and clearly set out a number of improvements. These included multi agency training to raise the profile and understanding about the LADO role, consistent application of thresholds for referral to the LADO by relevant organisations, and robust governance, accountability and scrutiny of the LADO function by senior leaders and the Doncaster Safeguarding Children Partnership. The local authority reports that all actions have been completed.

1.26 Our review has found that there was a lack of formal liaison arrangements between the LADO function in local authorities where residential settings are located and their counterparts in placing local authorities to alert them about enquiries into staff conduct. The Panel has therefore initiated urgent local assurance action, led by DCSs, to directly address this concern (see urgent action 2 below).

Finding 9

National regulatory arrangements had a limited impact on identifying and responding to the many concerns and complaints about children's safety and wellbeing. Children were left at continuing risk of harm.

1.27 Intelligence available to OFSTED from complaints, allegations and inspection evidence was not brought together with sufficient rigour to identify risk at the three settings and escalate earlier intervention. OFSTED has reviewed its response to parental complaints and the inspection of the children's homes over the period 2015 to 2021. It has initiated key changes in scheduling and co-ordinating inspections of residential special schools and care homes, and in training those conducting inspections to develop the professional curiosity required for placements such as those at Hesley's children's residential settings that exhibit a 'closed culture'. In phase 2 we will consider what changes may be required to the framework for inspection of residential settings, including the scope for a multi-agency inspection process with a focus broader than regulatory compliance.

1.28 Overall, it is clear that professionals in different roles across the system had separate information indicating degrees of concern about what was happening to the children at these settings. None of this was brought together into a considered view that would have triggered escalation and intervention. In phase 2, we will explore further the respective roles of different professionals in keeping children with complex health needs and disabilities safe. We will consider the extent to which the various sets of reporting requirements, quality standards, regulations and inspections provide a coherent and effective assurance framework and make recommendations for improvement and change.

Finding 10

Our in-depth analysis of the journeys into residential care of 12 children placed at Hesley's children's residential settings highlights key challenges in current provision for children with disabilities and complex health needs that limit their access to the right support at the right time.

1.29 A focus on the child's disability meant the greater complexity of need was often not recognised, particularly regarding the impact of adversity in early childhood. Early diagnosis concerns did not lead to effective, multi-agency follow-up and engagement. Offers of short breaks and family support were inadequate and insufficient. Many of the children experienced multiple education placements before residing at Hesley's children's residential settings in Doncaster. Often those placements ended outside formal processes, with no opportunity to plan for the child and review their needs.

1.30 In phase 2 we will examine the commissioning requirements for children with the most complex needs to ensure that they have access to the best provision to meet their needs in a timely way. We will look at best practice in commissioning and the potential for commissioning through statutory arrangements including new Integrated Care Boards. We will consider research evidence about alternatives to residential placements through such provision as specialist support services, family help, early diagnosis and preventative services and coordinated wraparound care.

Integrated education, health and care

1.31 The children were living together, educated together and had some of the same adults with them at school and in their home, but we found a lack of coherence and co-ordination between the safeguarding arrangements operated by staff in the schools and the care staff in the three residential settings. In phase 2 we will look at how leadership and management can be supported to promote an organisational culture which integrates education, health and care in a holistic, child-centred environment.

Urgent assurance action

1.32 The level and seriousness of the concerns raised by this review meant that the Panel needed to initiate action to provide assurance about the care and safety of children placed in similar specialist settings. Accordingly, the Panel has initiated urgent assurance action by Directors of Children's Services in all English local authorities, and by OFSTED ahead of the publication of this report to:

- ensure that placing local authorities have an up-to-date view about the progress, care and safety of children with disabilities and complex health needs from their area who are placed in residential special schools registered as children's homes;
- ensure that, for all residential special schools registered as children's homes, any LADO referrals, complaints and concerns over the last three years relating to the workforce have been appropriately actioned;
- ensure effective liaison between LADOs in 'host' local authorities with residential special schools registered as children's homes and the LADOs in placing local authorities in circumstances where there are enquiries not completed following allegations that a child has been harmed by a member of staff;
- understand current workforce challenges in these settings.

Our expectation is that these actions will be completed by the end of November 2022. Action to follow up concerns about the safety and care of individual children are the responsibility of the placing local authority. Concerns about individual settings will be reported to OFSTED for further investigation. Wider learning will be incorporated into phase 2 of the review.

Urgent Action 1

- Directors of Children's Services are to ensure that Quality and Safety Reviews are completed for all children with complex needs and disabilities currently living within placements with the same registrations (i.e., residential specialist schools registered as children's homes) to ensure they are in safe, quality placements.
- This action should be led and overseen by the placing (i.e., home) local authority DCS. If a review identifies concerns about the conduct of a member of the workforce, the placing local authority may need to share the concerns with the host Local Authority Designated Officer (LADO) if the threshold has been met.
- DCSs have been asked to provide an overview report on key findings and issues to both their local corporate parenting board and to local safeguarding partners, together with assurance that the Quality and Safety Reviews have been completed.
- DCSs have also been asked to send a copy of their overview report on the Quality and Safety Reviews to the relevant Department for Education regional improvement support lead (RISL). The Phase 1 review has highlighted how information may be held locally but that it is also important to develop a fuller and more comprehensive picture of quality in these type of placements. This will also allow for regional and national assurance that these actions have been undertaken.

Urgent Action 2

In relation to children with disabilities and complex health needs who are looked after children and who are currently placed in residential specialist schools which are registered as children's homes, all Directors of Children's Services should ensure:

- That the host authority LADO for each individual establishment reviews all information on any LADO referrals, complaints and concerns over the last 3 years relating to the workforce in such establishments to ensure these have been appropriately actioned.
- The host authority LADO should then contact any local authorities who currently have children placed in the establishments in their area if there are any outstanding enquiries being carried out regarding staff employed in the home.

DCSs have been asked to confirm that urgent action two has been taken within the overview report that will be provided to the Department for Education RISL on action one above.

Urgent Action 3

OFSTED to conduct an immediate analysis of their evidence around workforce sufficiency focusing on its suitability, training and support.

Phase 2: the residential special school and care system

1.33 In this phase, we will explore the wider issues raised by our findings in phase 1, including national recommendations for changes to policy and practice needed to keep children safe and well in residential placements. Phase 2 is due to be completed by spring 2023.

Phase 2: key lines of enquiry

- What needs to happen to ensure the voices of children with complex health needs and disabilities are listened to and heard, and their rights are respected and upheld?
- What are the respective roles of different professionals in keeping children with the most complex needs safe? What changes, if any, are required to improve their effectiveness?
- What are the conditions for efficient and effective commissioning so that children with complex health can access the very best support to meet their needs in a timely way?

2. Review methodology

2.1 Phase 1 of our review has been undertaken in the context of an ongoing criminal investigation. The methodology for the review was designed to ensure that evidence for the criminal investigation was not compromised and that individual children were not identifiable from the findings in our report. We have therefore been unable to engage with the families involved.

2.2 The review period in scope is January 2018 to March 2021. The rationale was defined by Operation Lemur Alpha and based on a number of key factors, including:

- an increase in the number of incidents involving physical interventions and restraints from 2019
- an increase in misadministration of medicines over the same period
- several whistleblowing reports to OFSTED, including Regulation 40 notifications
- an increase in allegations against staff and further whistleblowing concerns between 2018 and 2020 reported to the LADO in Doncaster
- complaints about children's care and safety by families or local authorities raised with OFSTED and/or their placing local authority

2.3 The first stage of our analysis was to collate data on the 108 children identified as in scope under Operation Lemur Alpha, drawing on an initial dataset provided by Doncaster Council. A second and larger set of data on each of the children was retrieved via a questionnaire completed by the home local authority of each child. The questionnaire was designed to gather further detail about their journey into placement at Hesley's children's residential settings. A copy of the questionnaire is provided at Appendix 2.

2.4 Once all of the data had been analysed, we used the information to determine a sample of 12 children who together represented, as far as possible, the trends and averages identified within the whole population of 108 children. We reviewed the relevant information held about them as part of Operation Lemur Alpha, including the pen portraits, life story packs and specialist observations. Group interviews were set up with the placing authorities. These included a range of professionals such as allocated social workers, heads of service, independent reviewing officers, multi-agency safeguarding partners, designated nurses, commissioners and special educational needs teams. In all we interviewed 51 professionals, the majority of whom were local authority staff. Their respective roles are listed in Appendix 3. These interviews were designed to help us understand the children's lives and key practice episodes before their placement at the settings, and to ascertain how the quality of care for each child was kept under review. Professionals were also asked to reflect on whether or not they felt things could or should have been done differently.

Triangulation with learning from Operation Lemur Alpha

2.5 As part of the protocol agreed with Doncaster Council and South Yorkshire Police, we have had sight of the interim investigation report from year 1 of Operation Lemur Alpha. It provides some of the evidential basis for our findings, particularly concerning the incidence of harm and abuse of the children in the three settings.

Law, policy and research literature on placement and safeguarding of disabled children in residential settings

2.6 In addition to our data analysis, we also commissioned work from the National Children's Bureau research team to understand the broader context for children with autism and learning disabilities, and the international research evidence about how they are best supported and safeguarded. The learning from their work has been incorporated into our wider analysis in this report and has informed the focus for phase 2 of the review.

3. Contextual information

The settings

3.1 Fullerton House, Wilsic Hall and Wheatley House are residential settings located within the Doncaster local authority area, forming part of a national provision run by the Hesley Group. The Hesley Group offers education and care up to 52 weeks per year for children and young people aged 8 to 19 with profound and multiple disabilities, complex needs including behaviour that may challenge, and learning disabilities often in association with autism. Fullerton House, registered by OFSTED to offer up to 44 placements, is set within a small former mining village from where it has recruited the majority of its staff. The residential school is housed in an old miners' hospital with the residential units housed in the adjacent streets on a relatively new social housing estate. Wheatley House is a newly built children's home comprising three adjoining and inter-linked two-bedroomed terraced houses within the village, with accommodation for up to four children aged 10 to 17 who require intensive care and support. Wilsic Hall, registered with OFSTED to offer up to 32 placements, is an old, grand house, set within large grounds in a rural setting. The accommodation is in blocks within the grounds.

3.2 Information for parents and professionals from the Hesley Group emphasised a holistic package of care and education, based on a model of positive behaviour support and including access to a range of therapeutic services including speech and language therapy, occupational therapy and specialist clinical psychology. Staff were trained in the Hesley Enhancing Lives Programme which promoted an approach based on therapeutic crisis intervention and included accredited training on safe, proportionate, physical intervention.

3.3 The settings are subject to the Children's Homes (England) Regulations 2015, which set out the quality standards and reporting requirements expected of each provider. OFSTED is responsible for inspecting residential children's homes against the quality standards, including a full inspection at least once a year. The residential care settings at Fullerton House and Wilsic Hall were suspended by OFSTED following assurance visits by OFSTED in March 2021.

3.4 The settings are under investigation by Doncaster Council and South Yorkshire Police for poor practice, poor leadership and management, and suspected criminality. The Hesley Group has provided a range of policy documents, training material and data requested by the Panel and made a formal written response to a series of questions. These responses have been taken into account in the findings in our report.

Profile of the children placed at the three settings

3.5 The children and young people in our review presented a wide range of vulnerabilities as a result of their disabilities and complex needs, as shown in the two case illustrations below. These are typical of the children's pathways to placement at one of the three settings.

Case Illustration 1: Jane

Jane was an affectionate, giggly girl who liked to laugh and socialise when her day was going well. When it wasn't, she could display behaviours which were both disturbing and challenging. Jane originally received support with a child-in-need plan and local short break services. However, these services became increasingly unable to support her as there was not an appropriate peer group for befriending and enrichment activities. The local authority was keen to find ways of meeting her needs locally, but this became more challenging for the family and she was eventually placed at Hesley's children's residential settings in Doncaster on a Section 20 agreement, over 100 miles away from home. Jane had a strong relationship with her family but it became increasingly difficult to maintain due to both distance and the additional impact of COVID-19.

Case Illustration 2: Noah

Noah moved to the UK from an EU state when he was three years old. He was described as happy and bubbly and he enjoyed playing chase. He had a number of diagnoses between the ages of two and six years old. There had also been domestic violence in his wider family. Noah was supported through a series of child in need plans over the course of five years, including a package of overnight short break support. Despite Child and Adolescent Mental Health Services involvement and a diagnosis of complex post-traumatic stress disorder, gradually his aggressive outbursts became seen as part of his disability rather than as a consequence of the experiences in his family environment. Noah's mother had moved area to keep him safe from wider family influences, but there was no support for her other than overnight short breaks, as the move left her isolated from her support networks. At the age of eight Noah went to live at Hesley, where he remained for the next three and a half years.

3.6 Doncaster Council's internal investigation has given us an insight into the children's likes and interests, the way that they were able to communicate their feelings (both verbally and non-verbally), and the things that made them feel happy and thriving. These are shown in the following graphic, drawn from the pen pictures of the children included in the social work life story packs created for the investigation.


spends time relaxing in the garden and is happy there.
growing in confidence, happy and content, fun, bubbly, caring
is affectionate and has a sense of fun
loves her house
very relaxed
very funny young man and a lovely lad
happy
observant
popular with staff and peers
able to make informed choices
happy
Enjoys playing chase
affectionate and cheeky
caring
Listens really well to instructions and interacts well with staff and peers.
excellent progress to promote her independence and dignity and self-worth
very smiley
fun to be around
likes to interact and play with others
mischievous with an infectious grin
Has a great smile
enjoys 1:1 interaction such as playing with people's hair and will initiate interactions by smiling and showing affection
funny and bubbly
likes to help others and 'have a job'
Fun, caring and talkative, enjoys tickles, fun activities, singing and dancing and snack time.
content
likeable young lady
loves to laugh and giggle

Key characteristics of the children placed at Hesley's Children's Residential Settings

3.7 Age, gender and ethnicity

We found that on average, the children were 13.8 years old when placed, and 16.8 years old when they left. Seven children were placed when they were under the age of 10, and 14 were placed over the age of 16. Over three-quarters were boys. The most common ethnic group was white (68%).

3.8 Diagnoses of disability

The most common diagnoses of disability were:

- autism (82%)
- learning disability (76%)
- global developmental delay (14%)
- attention deficit hyperactive disorder (25%)

Other diagnoses included hyperactivity and anxiety. Most of the children had profound difficulties with expressive and receptive communication.

3.9 Functional communication

Research indicates that disabled children who have difficulty in communicating needs and discomforts are at increased risk of abuse or neglect and have problems in communicating their trauma.[4] The Council for Disabled Children assessed the children's communication against a seven-point scale.[5] It found that 72% of the children had a score of:

- 5 (rarely effective verbal communication)
- 6 (non-verbal with use of shared symbols/communication systems)
- 7 (non-verbal without use of shared symbols/communication systems).

3.10 Adverse experiences

Half of the children were noted to have had at least one adverse experience. The three most common adverse experiences were neglect (24 cases), abuse (15 cases) and having a parent with mental ill-health or a mental illness (14 cases).

3.11 Distance placed from home

The children at Hesley's children's residential settings were placed by local authorities from all nine regions of England. Many of the children were placed a considerable distance away from home. The mean distance they were placed from their home authority was 95.16 miles, with a range of 7.3 to 267.1 miles. 60% of the children were placed over 50 miles away from their home. One child under the age of ten was placed almost 180 miles from home.

4 See Vervoort-Schel, J., Mercera, G., Wissink, I., Mink, E., Van Der Helm, P., Lindauer, R., & Moonen, X. (2018). 'Adverse childhood experiences in children with intellectual disabilities: An exploratory case-file study in Dutch residential care'. International Journal of Environmental Research and Public Health, 15(10), 2136. https://doi.org/10.3390/ijerph15102136
Hunt, H. (2008). 'Disabled children living away from home in foster care and residential settings.' Developmental Medicine and Child Neurology, 50(12), 885. https://doi.org/10.1111/j.1469-8749.2008.03179.x

5 The Council for Disabled Children adapted a communication function classification system that is used to classify the everyday, functional communication performance of people with cerebral palsy. This system was chosen as it provides a clear and graduated scale of a person's communication ability in terms of expressive and receptive communication in relation to familiar and unfamiliar people and how much time is needed to understand communication from others.

3.12 Legal status

Most of the 108 children had been placed under Section 20 (child looked after with parental agreement). Some of the children had more than one legal status during their time at the placement. All of the children had Education, Care and Health plans.

Legal status	Number of children
Full care order	24
Interim care order	3
Section 20	69
Care leaver	5
Aged over 18	7
TOTAL	108

3.13 Funding

80% of the children's placements were jointly funded.[6]

Placement funding	Number of children
Education, health, social care	55
Education, social care	26
Social care, health	5
Education	7
Social care	9
Health	4

6 The review team was not provided with the details of funding for two of the 108 children resident at Hesley's children's residential settings during the period in scope.

Legal framework and statutory guidance

3.14 A key consideration of the review has been evaluating the extent to which the statutory duties to the disabled children placed at Hesley's children's residential settings were executed and met. See Appendix 4 for information on the Children Act 1989, which is the primary piece of legislation in relation to looked after children, as well as other key statutory guidance.

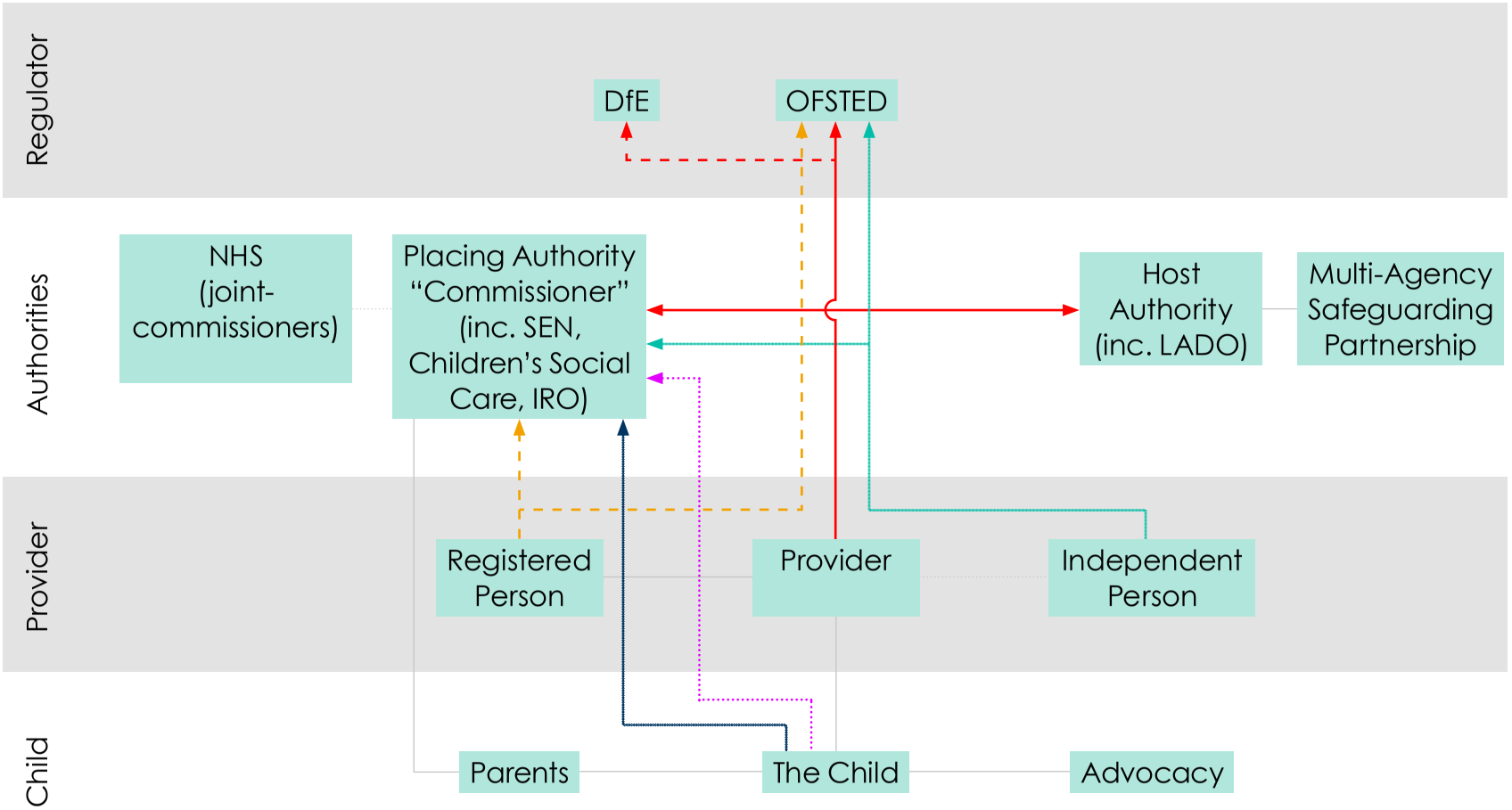
3.15 In the Children Act 1989, there is a 'specific' duty on local authorities to safeguard and promote the welfare of the children they look after. In addition, there are series of duties on the timelines for reviews and visits to individual children and young people dependent on their legal status. A child who is looked after must have their care plan, which includes a personal education plan and a health plan, reviewed according to the statutory schedule. This applies to children who are accommodated under Section 20 as well Section 31 (a full care order).

3.16 For a child whose special educational needs are met through an education, health and care plan, the Children and Families Act 2014 requires the home local authority to review the plan annually. This responsibility rests with the child's home local authority, even when the child is being educated outside the local area (as at Hesley's children's residential settings). Each of these statutory responsibilities needs to be fulfilled by the child's home local authority and one does not supersede the other.

Oversight and accountability

3.17 The children living at Hesley's children's residential settings were at the centre of a complex system of monitoring, oversight and quality assurance (as shown in the following diagram). An important area of focus in our report is the extent to which local and national arrangements for oversight and accountability for the children were effective in identifying concerns about their safety and wellbeing. The respective roles of providers, placing and host local authorities, and regulators, are summarised in Chapter 6, where we evaluate the impact of these arrangements at Hesley's children's residential settings.

Mechanisms for reviews and quality assurance



The findings

4. What happened to the children and young adults placed in these settings?

4.1 Evidence from the Operation Lemur Alpha investigation and our analysis indicates that children placed in Hesley's children's residential settings in Doncaster experienced experienced sustained, significant abuse and harm over an extended period of time.

Abuse and harm in the three settings

4.2 The nature and scale of the abuse and harm is set out in the table below, followed by two case illustrations. As these matters are under criminal investigation by South Yorkshire Police, the details are presented at summary level only and through case illustrations to ensure that the investigation is not compromised and that individual children are not identifiable.

Table 1: Summary of abuse and harm experienced by children and young adults at Hesley's children's residential settings 2018 to 2021

Type of abuse and harm	Description
Physical abuse and violence	Children and young adults experienced direct physical abuse from both staff and other residents. There were occasions of physical abuse being used as a form of discipline and evidence of excessive force against children and young adults. In the majority of cases, concerns about physical abuse were not investigated.
Neglect	Children and young adults experienced various forms of neglect by staff. This included physical neglect (for example, poor clothing) but there was also a failure to take account of cultural, religious and recreational needs. To a significant extent, the concerns around neglect were reflective of the wider organisational culture and poor practice in the settings.

Emotional abuse	Children and young adults experienced significant and varied emotional abuse by staff. Their distress was exacerbated in circumstances where there were high levels of violence between residents, which often went unchecked, leading to fear and anxiety that sometimes manifested themselves in self-soothing behaviours such as head banging or rocking.
Sexual harm	There was evidence suggesting that staff in the settings had seriously breached sexual boundaries with each other and with children and young adults.
Unmet medical needs	There were incidents of medical advice not being followed by staff regarding physical injuries to children and young adults and concerns of mental health deterioration.
Misused and maladministered medication	There were concerns that the settings were not compliant with Regulation 23 of the Children's Homes (England) Regulations 2015 regarding the management, administration and disposal of medication.

4.3 The impact on the daily lives and experiences of children and young adults placed at Hesley's children's residential settings is shown in two case illustrations.

Case Illustration 3: Fred

Fred was diagnosed with autism and had behaviour that could be seen as challenging. Given his limited verbal communication, he used certain types of behaviour to get his basic needs met. Before being placed at Hesley's children's residential settings, Fred had been taught to use the Picture Exchange Communication Scheme, a common method which enables young people to show staff pictures of what they need. Fred could use this to ask for food and drink, to go to the toilet and to show when he felt anxious. The scheme was not used with Fred at Hesley's children's residential settings in Doncaster, and there was limited evidence that staff working with him made effective use of the communication training from the Hesley Enhancing Lives Programme. As a result, Fred was deprived of his voice and choice. His behaviour escalated and became more challenging, leading to disproportionate and unjustifiable use of physical restraint.

Case Illustration 4: Jennifer

Jennifer was a sociable and engaging teenager. She liked spending time with people she chose to, but also valued her own private space. This had become more important to her as she went through puberty. Jennifer's experiences were very distressing. She had been forced regularly into solitude and deprived of her liberty by being locked down in her own room, even when she clearly needed support. She was also assaulted in her room by staff, violating the safe space she needed in order to regulate her behaviour.

4.4 All of the children in the three settings attended school at either Fullerton House or Wilsic Hall. Although they were living together, educated together and had some of the same adults with them at school and in their home, we found a lack of coherence and co-ordination between the safeguarding arrangements operated by staff in the schools and the care staff in the three residential settings. The learning from OFSTED inspections of settings similar to Hesley's children's residential settings emphasises the importance of an organisational culture which integrates education and care together in a holistic, child-centred environment.

Voice of the child

4.5 At Hesley's children's residential settings in Doncaster the wishes and feelings of the children were not routinely sought.[7] As children living away from home, they should have had access to independent advocacy support. We found little evidence that this was actively provided, with only two of the children in our review sample accessing independent advocacy.

4.6 For many of the children, effective involvement in formal meetings such as annual reviews or care reviews would have been challenging and required creative approaches, but we found few instances where this was attempted. Although the Hesley Enhancing Lives Programme training for staff included developing advanced skills in engaging with individuals who struggle to communicate, there was minimal evidence of these skills in practice to support children and young adults to participate in key review meetings.

7 This is a key requirement under regulation 7 of the Children's Homes (England) Regulations 2015,

4.7 Many of the children in scope had profound difficulties with expressive and receptive communication. As such, they would not have had the ability to describe something to another person clearly and articulately, or with detail. This meant that they would have found it difficult to report the abuse they had experienced, especially given they were not familiar with many people beyond the staff at Hesley's children's residential settings. Children's behaviours that challenge meant that visiting professionals were often unable to see them alone, which made the circumstances more problematic.

4.8 The staff at Hesley's children's residential settings did not respond effectively to allegations or disclosures from the children against staff members. Of particular concern was the response to non-verbal children who were displaying behaviours, signs and symptoms indicative of child abuse. There was a lack of recognition that behaviour was itself a means of communication, and that behaviour that challenges may signal a need for support. Incidents that indicated safeguarding risk were too often characterised as self-injurious behaviour that was deemed to be part of the child's disability. In these circumstances, there was an over-use of restraints and disproportionate use of temporary confinement. In some cases, staff at Hesley's children's residential settings in Doncaster had not been trained in the restraint techniques they were using, or were using them inappropriately.

Finding 1

There is evidence that children placed in Hesley's children's residential settings in Doncaster experienced sustained, significant abuse and harm over an extended period of time. The voices of the children and young adults were not heard.

4.9 A priority area of focus for the review in phase 2 will be what needs to happen to ensure the voices of children with complex needs and disabilities are listened to and heard (see chapter 8).

Placement far away from home

4.10 For the 108 children in scope for the review, the average distance between Hesley's children's residential settings in Doncaster and their home was 95 miles. Research evidence shows a clear link between the distance from the setting to the child's family home and increasing vulnerability to abuse.[8] Being placed far away from their home authority impacted on the ways in which different children were visited and reviewed by their social workers and family members.[9] Some social workers only saw their children when they returned to their home authority during school holidays, and therefore went long periods without seeing them in person. Parents also faced financial barriers to seeing their children, particularly where local authorities did not provide support with travel costs.

4.11 The protective factors afforded by supportive families were significantly compromised during the pandemic, with many of the children having limited contact with their parents and other members of their family. Some parents were able to visit their children in-person but were not allowed onto the premises – one parent saw their child from behind the fence to the placement building. This was a particularly significant barrier and caused distress for parents who lived far away from the placement.[10]

4.12 Professionals contributing to our review indicated that they were well aware of the importance of securing placements for children as close to home as possible. Nonetheless, they reported major difficulties in securing long-term placements for children with complex needs and challenging behaviour. The limited range of options available meant that in practice, a placement considerably far away from a child or young adult's home local authority was seen as the only viable course of action. This is a key challenge for the commissioning and development of specialist provision.

8 Nunno (2006), Learning from tragedy: A survey of child and adolescent restraint fatalities

9 The detailed requirements for visits to children in residential settings, as per the Children Act 1989 guidance and regulations volume 2: care planning, placement and case reviews. are set out in Appendix 4, pages 61 to 62. See also paragraphs 6.16 to 6.21. There are different requirements according to the legal status of the child. At Hesley's children's residential settings in Doncaster, almost all the children in scope had looked-after status. In the first 12 months of placement, visits should take place every six weeks, with visits every three months thereafter.

10 Arguably, such arrangements were not compliant with Children's Homes (England) regulation 22, which requires the registered provider to ensure that suitable facilities are available for child to meet privately with parents and carers. During the pandemic the regulation was modified to enable other communication methods if it was not possible to meet privately.

Finding 2

Placement far from home increased the children's vulnerability.

Appropriateness of the settings to meet children's assessed needs

4.13 Effective matching processes by the local authority and other partner agencies are vital for children when a residential setting is being considered to meet their assessed needs. These processes require good dialogue to establish that the setting can meet the child or young adult's care and support plan, and that the impact of the placement on the group of children and young adults at the setting had been considered.

4.14 Evidence from the Operation Lemur Alpha investigation and our analysis of the children's journeys indicates that the matching processes were inadequate for some children, leading to placements that were inappropriate for their needs and, on occasion, unsafe. The specialist observations conducted so far have concluded that five children placed at Hesley's children's residential settings in Doncaster could have been considered for support through foster care or semi-independent living instead.

Finding 3

Some children were placed at the settings inappropriately.

4.15 In phase 2 of the review, we will examine the essential criteria for assessing the suitability of commissioned placements so that children with complex needs and disabilities are placed in provision that is suitable, safe and meets their needs (see chapter 8).

Indicators of concern (2018 to 2021)

4.16 Operation Lemur Alpha emerged as a response to 12 allegations from whistleblowers in February 2021. However, there had been indications of concerns over the previous three years:

- OFSTED had carried out monitoring visits in response to concerns about staff shortages (Wilsic Hall 2019) and an escalation in Regulation 40 serious incident notifications (Fullerton House 2020)
- the LADO in Doncaster had received increasing numbers of allegations and concerns about the conduct of the staff at the three settings
- 43 of the local authorities completing questionnaires for our review reported concerns about what had happened to the children or the settings in general while they were staying at Hesley's children's residential settings in Doncaster

In spite of these known concerns, the overall system of external oversight did not prevent the emergence of a harmful culture to children at the settings, nor did it respond to concerns of alleged abuse in a focused or appropriate way.

5. Impact of leadership, management and culture

5.1 Fullerton House, Wilsic Hall and Wheatley House were subject to the Children's Homes Quality Standards set out in the Children's Homes (England) Regulations 2015. The quality standards emphasise the importance of a safeguarding culture and ethos where children are listened to, responded to, and both feel safe and are safe. Regulation 34 requires the registered person 'to prepare and implement policies for the safeguarding of children from abuse or neglect'.[11] There must be clear procedures for referring child protection concerns and arrangements for dealing with allegations concerning staff. The relevant policies need to be regularly reviewed and revised. This chapter evaluates the extent to which these key expectations of leadership and management were met at Hesley's children's residential settings.

A safeguarding ethos?

5.2 Research evidence highlights that the attitudes and behaviours of leaders, managers and staff in a residential setting are essential for creating an organisational culture in which good quality care and effective safeguarding flourish. A range of studies characterise that culture as reflective and progressive, with opportunities for staff to develop and learn. Managers lead by example and treat staff and the children with warmth, respect and value. Staff take opportunities to share good practice with colleagues. They are open in their interactions with children and young people and responsive to their needs.[12]

11 Department for Education, The Children's Homes (England) Regulations 2015

12 Commission (2005), 'Residential care and education: Improving practice in residential special schools in Scotland'; Franklin and Goff (2019), 'Listening and facilitating all forms of communication: Disabled children and young people in residential care in England'; Audit (2010), 'Getting it right for children in residential care'; Barron et al. (2019), 'Exploration of the relationship between severe and complex disabilities and child sexual abuse: A call for relevant research; Archer (2002), 'What workers in residential care: Making it work'

5.3 Information from the Hesley Group about the leadership structure at the settings described a comprehensive staff team comprising managerial, support staff and clinicians operating as a multi-disciplinary team to deliver a common therapeutic approach to support children. The policies and procedures that the Hesley Group provided to this review conveyed clear expectations about the role that senior staff should play in facilitating a culture of learning and leading by example to deliver good outcomes for the children and young people in their care. These expectations existed on paper alone. In practice, the policies were not implemented effectively and, in some cases, were actively violated. In contrast with the safeguarding ethos set out in the policies and procedures, evidence from OFSTED inspection reports in March 2021 showed that there were serious and widespread concerns in relation to the leadership and management of the settings.[13] The complex abuse investigation by Doncaster Council shows that a culture of abuse and harm prevailed, with limited action to challenge and limit it. It was a culture where children and young people's rights were not respected, their views were not heard and they were not protected.

A 'closed shop' mentality

5.4 The OFSTED inspections in March 2021 highlighted that leaders and managers did not develop learning from safeguarding incidents or take sufficient action to prevent further incidents of a similar nature. These concerns also applied to allegations of children being harmed by staff. Managers did not analyse patterns or trends to inform changes in approach to supporting the children where this was necessary. The inspection at Wilsic Hall also found a lack of transparency by managers in relation to the reporting of safeguarding incidents to the regulator.[14]

5.5 This pervasive, detrimental organisational culture was further embedded by the lack of involvement of other professionals. As Hesley's children's residential settings took on such an all-encompassing role in providing packages of support for children and young people, there was little input from other external agencies that may have challenged the culture and ways of working. Instead, they remained in a 'closed shop' mentality. As one practitioner reflected in our group interviews:

13 OFSTED inspection of Fullerton House, 18-19 March 2021; OFSTED inspection of Wilsic Hall, 23-24 March 2021.

14 OFSTED inspection of Wilsic Hall, 23-24 March 2021.

"These organisations being able to, they offer us an exclusive package … we'll provide residence, we'll provide education, we'll provide healthcare, we'll provide psychological assessment but I think culturally it just means it's very much a closed shop. Where do they then get their new, fresh ideas and new ways of looking at things? No one ever gets to look into and challenge the organisation."

Interim service manager, children with disabilities team[15]

This is not to suggest that all employees at the settings were complicit in the overt abuse taking place. However, within the context of this negative culture, staff were less able to share concerns within and outside of the settings. Evidence from Operation Lemur Alpha indicates that several staff did attempt to report their concerns to both managers and OFSTED, but at times those concerns were either not considered or were minimised by senior staff from Hesley's children's residential settings. There was also an indication that staff were unaware of policies relating to safeguarding complaints and whistleblowing, or did not actively use them. As a result, the policies could not, and did not, provide an enabling framework for staff to safeguard and support children placed at the settings.

Finding 4

Leadership and management in the three settings were inadequate and failed to meet statutory requirements, resulting in a culture of poor practice and misconduct by care staff.

15 Unless otherwise stated, the professionals quoted are from local authorities.

Workforce issues and their impact on the quality of care

5.6 Data provided to the review team from the Hesley Group indicates that the organisation experienced major challenges regarding staff recruitment and retention, with staff turnover across the two settings averaging 38.6% during the period of the review in scope (2018 to 2021). Concerns relating to the workforce were raised in a monitoring visit to Fullerton House by OFSTED in June 2020. The visit identified 'a developing culture in which a small number of staff are bullying each other' and 'a large turnover of staff' which was having an impact on the overall aims and outcomes of the home. Evidence gathered by Operation Lemur Alpha confirmed the findings of the OFSTED report, highlighting concerns that children and young people in the settings were not provided with the appropriate ratios of staff and the level of supervision in accordance with their needs, risk assessment and care plan. In these circumstances, there were incidents of children being harmed by other residents. On occasion, they were able to leave their settings and were found in unsafe situations.

5.7 The Children's Homes (England) Regulations specify that staff should complete an appropriate induction and have the experience, qualifications and skills to meet the needs of each child. Evidence gathered for Operation Lemur Alpha indicates that limited induction was given to some staff, and there were instances where subsequent training records for staff were out of date. Some staff did not have sufficient knowledge or training to recognise the signs that children or young adults were at risk and know how to respond. As a result, risks were not mitigated and robust practices to protect vulnerable children and young adults were not followed.

Poor residential care practice

5.8 The impact of ineffective leadership and limited workforce capacity was reflected in the poor practice experienced by the children and young people in the settings. Stated practices to respond to the complex needs and vulnerabilities of the children placed at Hesley's children's residential settings in Doncaster were not applied by practitioners in their day-to-day work with the children, as illustrated through the following examples.

Practice example 1: positive behaviour support[16]

The restrictive interventions reduction policy for the settings stated that positive behaviour support 'will be an integral part of people's individual plans, underpinning all aspects of the person's daily experience … The staff implementing this plan will be trained for this role and their immediate managers/supervisors given appropriate training for them to effectively support the member of staff concerned … If staff are having difficulty delivering the plans, they must ask their manager for guidance. The support being delivered should match the plans … Staff must not 'do their own thing'.

In spite of this clear policy requirement, there is evidence that staff did not understand and apply the principles of positive behaviour support in responding to behaviour that challenges, for instance in recognising behaviour as a form of communication. Behaviour support plans were not followed.

Practice example 2: use of life space interviews

Although policy documents from the Hesley Group referred to the use of life space interviews as a means of involving and empowering young people, evidence from Operation Lemur Alpha suggests that this does not seem to have been implemented.[17]

16 Positive behaviour support is 'a person centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge. It is a blend of person centred values and behavioural science and uses evidence to inform decision-making….Behaviour that challenges usually happens for a reason and may be the person's only way of communicating an unmet need. Positive behaviour support helps us understand the reason for the behaviour so we can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen.' (Care Quality Commission briefing guidance, 2017)

17 Life space interviews are a crisis intervention approach to manage and change children's behaviour, which has been adopted in residential settings. Life space interview techniques can be used in an immediate response to a crisis event involving the child, or as part of more in-depth counselling and support.

5.9 Evidence from Operation Lemur Alpha identified notable instances where practitioners working in the settings diverged from support plans for young people that had been provided by the placing authorities. One example concerned occasions where staff used restraints on young people despite the fact this diverged from specific requests from the home authorities (recorded in internal Hesley Group documentation) not to do so. Another example was not using specialist equipment for children and young people that had been specified in their care plans, including helmets for head protection and weighted blankets.

These examples of poor residential care practice clearly demonstrate a lack of internal oversight from senior managers and a failure to act on the poor practice that children and young people experienced.

Finding 5

High rates of staff turnover and vacancies, as well as poor quality training, support and supervision, were significant factors affecting the children's quality of care.

5.10 In the light of the concerns about leadership, management and workforce development, the Panel has asked OFSTED to conduct an immediate analysis of their evidence around workforce sufficiency focusing on its suitability, training and support. (Urgent Action 3, see chapter 9.)

6. Impact of systems of quality assurance and national regulation

Introduction

6.1 There were many occasions during the period in scope that should have triggered an escalation of concerns about the provision at the settings. In this chapter we look at the effectiveness and rigour of the wider safeguarding system in identifying and responding to the array of concerns and complaints about the safety and wellbeing of the children at Hesley's children's residential settings in Doncaster. We consider in turn the roles of:

- The Hesley Group – statutory reporting requirements
- the placing local authorities – care planning, reviews, monitoring of placements and visits
- the 'host' local authority – management of concerns and allegations
- OFSTED

Statutory reporting requirements

6.2 The Children's Homes (England) Regulations 2015 place specific record keeping and reporting requirements on the registered provider. These reports should be provided routinely to OFSTED and the placing local authority for each child. For the registered provider, the reports should support a culture of reflection, learning and continuous improvement. The information enables OFSTED to maintain an overview of the wider context of the setting and any emerging signs of risk. For the placing authority, the reports should give an indication of what daily life is like for the child or young adult in placement.

Regulations 35 to 39

6.3 These regulations specify the records that must be kept in residential children's homes, including each child's case records and records of the use of a measure of control, discipline or restraint in relation to a particular child. Operation Lemur Alpha has found evidence of poor quality record keeping and storage of the children's records at the three settings.

Regulation 40: serious incident notification

6.4 Regulation 40 requires the registered person to notify OFSTED, the placing authority and other partners when a serious incident occurs. Some incidents are clearly defined as serious and will require an automatic notification, such as a child death (which must also be reported to the Secretary of State for Education) or an allegation of abuse against someone in the home. For other incidents, the definition of serious is more ambiguous, and it is up to the registered person to decide whether it meets the requirements of a Regulation 40 notification.

6.5 In respect of the provision at the settings, Operation Lemur Alpha has raised concerns about the under-reporting of serious incidents to OFSTED and the placing local authorities. Of particular concern was that records of allegations and serious incidents were held in separate 'allegations books' outside of policy. In some cases, there were 'bespoke' allegations books on specific children and young adults.

In August 2021, during an assurance visit, OFSTED identified additional bespoke allegations books held for five children with a tracker of incidents and restraints that were not notified to the home local authorities.

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The material held in these books was not shared with OFSTED or the placing local authorities. As a result, risk, abuse, harm and injuries to children and young adults remained hidden and unreported, with placing local authorities unable to investigate the concerns and mitigate risks to the children.

Regulation 45: registered person review of quality of care

6.6 Regulation 45 of the Children's Homes (England) Regulations 2015 requires the registered person to review the quality of care for children at the home every six months. The findings of the review should be set out in a report (to be sent to OFSTED and available on request to placing local authorities) detailing how the home was providing adequate quality of care to children and young people, and how this evolved over time. The report must also identify improvements required and include the views of the children in the home. In respect of the settings at Hesley, there were periods when the registered person had not completed the review in a timely way. This report should have been a tool for self-evaluation and practice improvement, ideally as part of a dialogue between the providers at Hesley, placing local authorities and OFSTED, but we found limited evidence of such dialogue in practice.

Regulation 44: independent person reports

6.7 Regulation 44 of the Children's Homes (England) Regulations 2015 required the Hesley Group settings to appoint an independent person to visit the children's home at least once each month and scrutinise the actions of the provider. These visits can be unannounced, culminating in a report which asserted the independent person's views as to whether children were effectively safeguarded and whether the conduct of the home promotes children's wellbeing. The report should be sent to OFSTED and the placing local authorities. It may also be sent to the host local authority on request. Internal investigations in Doncaster have found evidence to suggest that the independent persons appointed at Hesley did not always have the necessary impartiality to provide critical scrutiny. This may explain, in part, why some Regulation 44 reports, although timely, appeared to be over-optimistic in nature.

6.8 The Children's Homes Quality Standards lack specificity for settings for children with complex needs and disabilities. Where there are references to children and young people with complex needs, they do not set out clear and specific standards for meeting their needs and keeping them safe. The guide to the Children's Homes (England) Regulations 2015, including the quality standards, states that:

'Some of the requirements of the standard must be applied in such a way that homes are able to protect and meet the needs of all children accommodated in them (particularly in relation to children's complex special educational needs and disabilities). Children should have the appropriate level of freedom and choice granted to them, however, for some children, ensuring their safety and welfare means that this may be limited compared with other settings.' [18]

The lack of specificity in the quality standards cannot be used to justify the poor residential care practice found at Hesley's children's residential settings in Doncaster. It is arguable, however, that in the absence of clear and specific standards, there was undue discretion for the Hesley Group to claim that they were able to provide appropriate and safe placements that could meet the needs of the children placed there.

18 Department for Education, 'Guide to Children's Homes Regulations including the quality standards', April 2015

Finding 6

The settings demonstrated significant weaknesses in their compliance with statutory reporting requirements under the Children's Homes (England) Regulations 2015. Inaccurate and inconsistent record keeping and statutory reporting by the settings meant that OFSTED and the placing local authorities often had a false picture of the care, safety and progress of the children.

The placing local authorities

6.9 When a child is looked after, the placing local authority maintains the role of corporate parent and must work with multi-agency partners to safeguard and promote the welfare of the child. The child must have an allocated social worker who is responsible for developing their care plan and ensuring it is delivered. An independent reviewing officer will scrutinise the care plan and ensure that it reflects the views and needs of the child, providing challenge when identified needs are not being met. Where a child has an education, health and care plan, they may have a variety of other professionals involved in their package of care, including from the education or special educational needs team, the children with disabilities team, NHS commissioners and the continuing care team. The related nature of these plans and reviews means that local authorities and relevant partners need to consider how these duties can be carried out in a co-ordinated way to best meet the needs of the individual child.

Monitoring of placements

6.10 A key aspect of the placing local authority's corporate parenting role is to maintain an up-to-date and detailed understanding of what is happening to the child they have responsibility for. It is vital that monitoring of the placement by the local authority is proactive and challenging to ensure the child's progress, safety and welfare. This was particularly important for children placed in the settings with Hesley, where formal reporting mechanisms under Regulations 40, 44 and 45 were providing a partial or possibly misleading account of a child's circumstances. Evidence from local authority questionnaires and our interviews with professionals indicates that this key care planning responsibility did not happen consistently. It was clear from the interviews that many of the professionals within placing authorities did have a meaningful understanding of the child they had placed, their preferences and interests, communications styles, and the importance of their family relationships. However, this knowledge did not lead to probing questions about children's lives at the settings until the whistle blowers made their allegations in February 2021.

6.11 Our interviews suggest that placing authorities were highly reliant on the settings providing them with accurate and timely information about what was happening with the children they placed there, particularly given how far away some children and young people were placed. Absent or incomplete reporting meant that some incidents were obscured, and therefore authorities did not develop an accurate and credible view of what life was like for the child or young person.

"A previous social worker on a couple of occasions had phoned Fullerton to have a check in, maybe the day or two days after there's been an incident but hasn't been informed of anything happening. In fact, she's put in her case notes, 'Asked if everything OK? Yeah, no issues, no problems'. But when you've found all those backdated things, it's highlighted that there have been massive incidents."

Social worker

6.12 More than half of the placing local authorities that we interviewed did develop concerns about the nature of the information they were receiving from the Hesley Group. The information was often incomplete or lacked details of specific action taken at the setting to respond to concerns. Often, the action by placing local authorities did not lead to concerted action to address the initial source of the concern, or to ensure that information requested from the settings was received. In some placing authorities, no response to the concerns raised reflected a lack of clear escalation processes.

"The local authority could have been a bit more robust in not accepting comments or statements from the Hesley Group, because there were quite a few incidents where records weren't being produced and the local authority wasn't receiving weekly or fortnightly or monthly reports from the group."

Team manager, children with disabilities team

6.13 The exact nature of the relationship between the provider and placing authority was not always clearly articulated. As the provider, the Hesley Group took on significant responsibility not only for the provision of care and support, but for the monitoring and evaluation of the impact of that provision. The placing authority fulfilled a lighter touch role in signing off the reports of progress from the settings. In situations where children with complex needs and disabilities were hard to place, the relief of finding a setting that had agreed to meet all the child's needs was so strong that detailed interrogation of the reports provided from the settings did not happen in the way that it should have done.

"What we can't see is any external viewpoint being brought in on this. Hesley observe it, they mark their own behaviour, they determine their own outcomes from it ... We haven't critically engaged with that particular issue; we accept on face value what Hesley group are telling us."

Service manager, children with disabilities team

6.14 This dynamic could have been exacerbated by workforce pressures across the system, with high turnover of social workers, team managers and staff responsible for commissioning. Some of the children in the review sample were known only through written records, with consequent impact on the quality of oversight. Limited capacity to undertake visits to children placed a considerable distance from their home local authority was also a factor.

6.15 A number of placing authorities reflected on the contrast between their perception of the complexity of the child placed at the settings, and their superficial understanding of what the child's life there was actually like. This was identified by some authorities as a key learning point, where greater challenge and interrogation of what they were being told by providers should have been pursued, including triangulation against other independent sources of information about the child.

"With hindsight, I think there should have been a greater level of curiosity about what was happening, but a lot of what was described in terms of the incidents seemed to fit with what we understood about how [the child] generally behaved."

Director of quality assurance and performance

Visiting

6.16 Placing authorities have statutory duties to visit the children in residential care who they have responsibility for. Depending on the child's legal status, this could include their social worker, an independent reviewing officer, professionals from the special educational needs or education team, and a commissioner. These visiting requirements are a crucial part of the monitoring and safeguarding system. The degree of proactivity of individual local authorities in some cases impacted on the ways that the children were reviewed and safeguarded while at the setting, both before and during the pandemic. The learning prompts us to reiterate the critical importance of timely, high-quality, statutory visits and reviews, with careful recording and systematic follow-up to ensure that children are receiving the care and educational support they need to make progress and achieve positive outcomes.

6.17 There was evidence of good practice from placing authorities, with some social workers travelling up to 200 miles and staying locally in Doncaster to be close to the children and regularly visiting them. One authority brought reviews forward after noticing that children were losing weight, and others successfully challenged their child's placement to permit face-to-face family contact during the COVID-19 lockdowns.

6.18 A limiting factor in these visits was that children were often not seen alone. The perceived nature of their needs meant that they required continuous support by staff from the settings. This was a major tension, undermining the opportunity for social workers to build authentic relationships with the children, understand what life was like for them in the setting, and to offer a safe, trusting environment where they might make disclosures.

"The placement was present, [the child] was also present because some of them are not, and her parents were always there as well. She was not seen alone due to her needs. She always had two-to-one or three-to-one support workers. So, it wasn't a typical visit as you would expect in terms of the social worker seeing a child alone."

Service manager for audit and practice standards

6.19 There was a risk of fragmentation between different teams involved within the placing authority. In particular, the roles of special educational needs and disabilities teams, social work teams and health teams were not always fully aligned, with a lack of clarity about their respective roles. Some placing authorities instituted joint visits between these various teams. This was perceived to be a positive arrangement and the role of the independent reviewing officer was valued as a helpful source of co-ordination and support.

"I think part of the strength that we've had as well is commissioning joint visits."

Social worker

"The independent reviewing officer is critical in all of this as well. They're the person who comes in every six months and apart from having an overview of the file, then have the ability to see things, feel and touch differently if that makes sense … They can be there as the extra pair of ears and eyes for the social worker."

Director of quality assurance and performance

6.20 This analysis has re-emphasised the recommendation in the special educational needs and disabilities code of practice that 'for looked after children the annual review [of the education, health and care plan] should, if possible and appropriate, coincide with one of the reviews in their care plan and in particular the personal education plan element of the care plan.'[19]

6.21 The impact of COVID-19 created significant disruption to placing authorities' visits to the settings, with many visits restricted to virtual formats which could be difficult to conduct without significant support from home staff. It also changed the structure and location of the face-to-face visits that did occur. As there was limited access to inside the homes, children and young people were seen outside with personal protective equipment.[20]

"There were about seven visits, May 2020 to January 2021, that weren't in the home. One of which I think was a telephone call right at the beginning of the lockdowns and then as they got the processes, the rest were outside or to the shops. So, I think there were seven visits in total where we didn't get access to the house."

Children's continuing care team leader

6.22 A number of interviewees reflected that this significant disruption to their ability to physically visit the homes and see the children in person had been a major factor in the risk of harm escalating.

19 Special educational needs and disabilities code of practice: 0-25 years, January 2015, paragraph 9.169.

20 The Adoption and Children (Coronavirus) (Amendment) Regulations 2020 did not restrict visits but recognised that if it was not possible to meet privately then to use other communication methods.

"There would have been probably more eyes on [the children]. I think a massive thing that we need to take [from this] is actually no one had eyes on any of these children for a very long time, and it just goes to show what happens."

Children's continuing care team leader

"If her behaviour was changing, it was being explained away as being about the pandemic, as opposed to potentially that she was then experiencing abuse from potentially inexperienced staff. But there wasn't the potential to be professionally curious because it was explained away by the pandemic, and her behaviour by not being able to go out and having different people around her."

Service manager for audit and practice standards

Finding 7

Quality assurance processes in the local authorities placing children at the settings were inconsistent and did not enable them to have a full picture of the children's progress, welfare and safety.

6.23 To ensure that placing local authorities have an up to date view about the progress, care and safety of children from their area living in residential special schools registered as children's homes, the Panel has initiated urgent action, led by DCSs, for the completion of Quality and Safety Reviews for each child. An overview of the findings is to be reported to the local corporate parenting board, safeguarding partners, and RISLs. (Urgent Action 1, see chapter 9.)

The host local authority: management of concerns and allegations

6.24 Working Together to Safeguard Children 2018[21] requires that every local authority has a designated officer role (LADO) responsible for the management and oversight of child protection allegations made against staff and volunteers who work with children and young people. An allegation may relate to person working with children who has:

- behaved in a way that has harmed or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child in way that indicates they may pose a risk of harm to children, or behaved in a way that indicates they may not be suitable to work with children

6.25 The LADO function in Doncaster during the period in scope was delivered by Doncaster Children's Services Trust, acting separately from, but on behalf of, Doncaster Council. At an early stage in the Operation Lemur Alpha investigation, it became clear that since 2018 there had been significant and increasing numbers of allegations reported to the LADO against staff at Hesley, which had been the subject of an internal investigation by Doncaster Children's Services Trust in June 2020. As a result, the Director of Children's Services (DCS) commissioned an independent review into the effectiveness of the LADO function in Doncaster, and the response through the LADO function to the increasing number of allegations and concerns regarding staff working at the settings.[22] The review found that poor work by the LADO in Doncaster up to 2020 meant that allegations were not investigated to a satisfactory standard, leaving children not adequately considered or safeguarded. The LADO role had not been effective in bringing together information from a range of sources to analyse the pattern of safeguarding concerns about staff at Hesley.

21 See Working Together to Safeguard Children 2018, chapter 2, paragraphs 4 and 5.

22 A summary of the findings, known as the third party report, has been made available to the review team.

'Managers and leaders should have collated and considered increasing reports and concerning information with partners from a child safeguarding perspective at a much earlier stage;… No attempt was made to bring placing authorities together… to share information, despite the majority of allegations focusing on children outside Doncaster'.[23]

Third party report

6.26 Following the independent review, Doncaster Council initiated a number of improvements including: multi-agency training to raise the profile and understanding of the LADO role, consistent application of thresholds for referral to the LADO by relevant organisations, and robust governance, accountability and scrutiny of the LADO function by senior leaders and the Doncaster Safeguarding Children Partnership.

Finding 8

There were major failings in operation of the LADO function, resulting in allegations about the conduct of staff in the residential settings not being investigated to a satisfactory standard.

6.27 Doncaster's independent review also highlighted the lack of liaison between Doncaster as 'host' local authority and the placing local authorities. Evidence from the placing local authorities suggests that there was confusion over the nature of the relationship between the placing authority and the LADO:

"Because we weren't managing the LADO process, it would have been Doncaster as host and Hesley Group as the employer. We weren't always as in the loop about, well, what the outcome was. Because actually what we needed to know was that the matter had been addressed and investigated. We were responsible for looking after that young person … There was often a reluctance to keep us up to date about the lower-level intervention."

Interim assistant director, children's social care

23 Third party report, page 7.

The Panel has initiated urgent local assurance action, led by DCSs, to directly address this concern (see urgent action, chapter 9).

6.28 A wider consideration is the lack of consistency of approaches between LADOs in different local authority areas. This is particularly evident in the application of thresholds for LADO action, notably at the points where other parties need to become involved in the investigation of concerns. Particular challenges relate to the ongoing oversight in place where an external investigation is not taken forward but 'low level' concerns are passed back to the provider for action. The independent management review found that actions taken by the LADO function in Doncaster during the period 2018 to 2020 were not always consistent, appropriate or proportionate, echoing similar concerns about the LADO function generally that have been reported in serious case reviews and in evidence to the Independent Inquiry into Child Sexual Abuse.[24]

The role of OFSTED

6.29 OFSTED is responsible for inspecting residential children's homes against the Children's Homes Quality Standards and has an obligation to inspect homes once a year. Where inspection has found a children's home to be inadequate or requiring improvement they should be inspected at least twice a year. In addition to scheduled inspections, OFSTED also plays an important oversight and co-ordination role as the single organisation receiving Regulation 40, 44, and 45 reports, as well as LADO referrals, anonymous concerns and whistleblowing. This should enable OFSTED to understand the emerging signs of risk, not only from an increase in Regulation 40 reports and referrals to the LADO, but also from an awareness of wider contextual changes in settings. Where concerns are identified, OFSTED can undertake unplanned and unannounced visits and retains the power to suspend the provision.

6.30 OFSTED inspected the children's homes at Fullerton House and Wilsic Hall in 2015. OFSTED judged that that there was a decline in effectiveness at Fullerton House and served compliance notices. Wilsic Hall was judged as requiring improvement. Subsequent inspections before the emergency inspections in 2021 confirmed that the concerns had been addressed.

24 See, for example: Medway LSCB Serious Case Review: 'Learning for organisations arising from incidents at Medway Secure Training Centre', section 5.8 (January 2019)

6.31 The school provision at Fullerton House and Wilsic Hall was subject to separate inspections by OFSTED. The most recent inspections of the schools were in autumn 2015 and 2018. Fullerton House was judged to be good on both occasions, while Wilsic Hall was judged as outstanding in 2015 and good in 2018. The schools had three additional emergency inspections in response to complaints.

6.32 Looking back over the period 2018 to 2021, it is clear that the intelligence from complaints, allegations and inspection evidence was not brought together with sufficient rigour to identify risk at the three settings and escalate earlier intervention. A key learning point from the series of inspections is the importance of robust professional curiosity and challenge to ensure that inspection goes beyond the evaluation of narrow regulatory compliance. This includes rigorous evaluation of patterns of notification and complaints over time which should prompt further enquiry. OFSTED has since carried out a review of its response to parental complaints, inspections of the children's homes from 2015 to 2021, and the inspection of the residential school provision. Drawing on the learning from the review, OFSTED highlighted five key changes as follows:

- the dates for the inspections of residential special schools and children's homes should be aligned, so that the provisions are inspected at the same time, wherever possible
- the last children's home report should be included in the pre-inspection information for the school inspection
- school inspectors should be briefed on safeguarding concerns, and information about complaints should be made available from the regulatory inspection manager
- inspection training should include training about 'closed cultures' in special education needs and disabilities settings, and the implications of this for the inspection
- inspectors conducting inspections in provisions where children and young adults may be non-verbal will have the requisite knowledge, skills and experience

The learning from the review is being taken forward by OFSTED with a detailed action plan, which includes improved systems for identifying providers who present a risk, as well as arrangements in regional teams to improve the monitoring, oversight and analysis of Regulation 40 and 44 reports and complaints.[25] Robust implementation of these changes will be crucial for developing a more effective regulatory system for these settings in future.

Finding 9

National regulatory arrangements had a limited impact on identifying and responding to the many concerns and complaints about children's safety and wellbeing. Children were left at continuing risk of harm.

6.33 It is clear from this analysis that professionals in distinct roles across the system had separate information indicating degrees of concern about what was happening to the children at the settings. None of this was brought together into a considered view that would have triggered escalation and intervention. In phase 2 of the review, we will explore further the respective roles of different professionals and regulators in keeping children with complex health needs and disabilities safe. We will consider the extent to which the various sets of reporting requirements, quality standards, regulations and inspections provide a coherent and effective assurance framework and make recommendations for improvement and change.

25 Complaints concerning Fullerton House and Wilsic Hall – OFSTED learning review and action plan, April 2022

7. The children's journey into placement at the settings

7.1 Introduction: a sample of 12 children and their journeys

In this chapter, we analyse the journeys of 12 children into placement at Hesley's children's residential settings in Doncaster. They are representative of the range of backgrounds and experiences of the 108 children who had been resident at the settings between January 2018 and March 2021. The children had vastly different family backgrounds and experiences, but for each one there was multi-agency agreement that their needs could only be met in a residential setting. From our analysis, we have identified four key aspects of practice in which, acting singly or together, the way that local services assessed and responded to the children's needs had increased the likelihood that they might need a residential placement.

Unrecognised complexity of need

7.2 Detailed analysis of the needs of the 12 children in our sample presents a very challenging picture. Half of them had known adverse experiences in their early childhood, some relating to significant levels of abuse and neglect. In addition, many had experienced multiple placements, which sometimes would have involved changing home as well as school.

"So not only have we got a child who's been removed from their parents, which is significant for any child, but we've also got a child who is one of quite a large sibling group … And then on top of that, there is additional needs, you know, the disability ... as well. So those things are traumatic for any child without some level of understanding or communication to be able to talk through, even with things as basic as social stories and that kind of thing. So I think in some ways, the impact of that was significant."

Social work team leader

While this complexity was recognised by professionals, we found few examples of interventions to address it. This was often because the child's disability became the overwhelming focus, or placement moves meant that specific support to address their adverse experiences could not be completed.

"She needed emotional support as well, because of the complexities of the trauma. There were more professionals who were needed for that intervention work. It was quite specialist, so we did as much as we could within the time scales that we had … It's just that unfortunately, we didn't have, as I say, the timescale to do the full intervention."

Social worker

Lack of early multi-agency engagement

7.3 The journeys of the 12 children show early diagnosis but limited follow-up. After diagnosis there was scant evidence of effective multi-agency planning and intervention, despite the fact that the diagnostic and early safeguarding risk factors should have highlighted the likelihood that these children's needs would spiral. Where learning disability and child and adolescent mental health services teams were involved, this tended to be isolated activity rather than integrated into multi-agency planning and review processes.

Inadequate and insufficient short break and family support

7.4 Although 10 of the 12 families in our sample received a short break offer, there were limits on the extent to which the provision could be tailored and extended to respond to changing needs. Two of the local authorities mentioned that the family or carers had reached the 'ceiling' of the overnight short breaks offer, at six or seven nights a month. Two children were unable to access short breaks.

"[We need] provision that would enable us to keep these complex children and young people at home for longer. This is a mum who very definitely wanted to be able to care for him, but what we needed was probably more than what … we would traditionally see from a local authority care. That sort of provision is not readily available."

Clinical commissioning group, commissioning performance and quality

In situations where an increase in levels and types of short breaks over time had been considered in line with escalating needs, that consideration did not extend to include wider family support needs or interventions.

"[The child was] initially supported with a fairly small short breaks package, which would be appropriate for a child of that age. Often for children under five, we wouldn't have very large packages."

Strategic lead for looked after children

7.5 Most local authorities did not report the provision of any 'family support', such as parenting support, support in the home, support with behaviour strategies, or support for parental mental health. Where support was offered, there was tacit recognition from some professionals that what they had been able to offer had been insufficient to sustain and support the family's role as a protective factor and enable parents to manage their children's care effectively.

"There were other behavioural interventions, which are being looked at here ... There are some recommendations, [but] it's mainly around positive praise, it doesn't look to be a very intensive type of work."

Service manager, children with disabilities team

7.6 Two families received time-limited Child and Adolescent Mental Health Services support for parenting and behaviour strategies. Three were offered support but either declined it, did not consent to the assessment needed to access it, or never received it because the situation deteriorated too quickly and the child became looked after before support could be put in place.

"[X] was permanently allocated a worker from the team (social work assistant) when he began receiving overnight short breaks."

Social work manager

7.7 Our interviews with professionals and the child's journey mapping activity indicate that often a social worker or social work assistant had been allocated because a young person was in receipt of short break support. This approach was in line with ensuring that proportionate and less intrusive pathways to short break support were available for families.[26] Where this happened, there was an indication that other frontline practitioners tended not to escalate increasing or new needs and concerns as there was an assumption that, with children's social care involved, others would follow up the issues.[27] This led to reviews of short break provision sometimes being the only point where escalation of needs was identified. It was often too late, with families already falling into crisis and creating a situation where disabled children were seen as the 'problem' within a family. The 'solution' was to give families a break from caring, but without underpinning that support with any wider family intervention.

"[X] was referred to a specialist family support service in 2013 and allocated 18 days through the local offer. A year later, a review of short breaks was undertaken and [X's] parents were signposted to additional activities in the community. Short breaks were reviewed again a year later as it was clear that the child's needs were still not being met, and an extended childminding resource was allocated. 18 months later a further review of short breaks happened and playscheme changed to another provision.

26 Bennett (2016), 'Promising practice from phases 3 and 4 of the Council for Disabled Children's learning and innovation programme'

27 Our analysis reflects research evidence found in Franklin et.al. (2022), 'UK social work practice in safeguarding disabled children and young people: A qualitative systematic review'

A social work assessment was carried out … following a referral raising concern for parental conflict. The parents were clearly very stressed … Overnight short breaks were agreed May 2017 … A review of short breaks occurred in May 2019 … and increased to three nights per month. This was the maximum capacity for community support and when this was still not sufficient to meet the child and family need, the only alternative is a residential school placement."

Social worker

7.8 The picture that emerged of inadequate and insufficiently expert support for families is supported by research evidence. Adequate and sustained family engagement is described across 14 research reports as a successful preventative measure that is not seen enough in reality. A UK expert has observed that many parents have felt unsupported for so long that they now have difficulty engaging with help offered.[28]

Multiple education placements

7.9 The analysis of the questionnaires to all local authorities indicated that only 25 of the 108 children were reported to have been excluded from school before moving to placement at Hesley's children's residential settings in Doncaster. This was a somewhat surprising finding given the previous research on children with complex needs and disabilities, which indicates a history of multiple failed education placements.[29] However, when we started to look in detail at the children in our sample, it was clear that the questionnaire responses might not have conveyed the full picture. Ten of the 12 children had experienced multiple education placements before their arrival at the settings, with some of them being told that their needs could not be met by the school and that they were unable to return.

7.10 Our conversations with professionals indicated a reluctance to use the language of exclusion and to present the situation as a 'managed move' process. However, there was little evidence that these moves were managed and timely, or that alternative placements were explored before the placements ended.

28 Sholl (2020), Commentary on 'A reflective evaluation of the Bradford positive behaviour support – in reach service'

29 Challenging Behaviour Foundation (2015).

"Because it's not my experience of working in the children with disabilities team that exclusion is something we talk about in this setting. It's actually that we can't meet need. And it's usually at the tail end of trying a lot of different bespoke packages, trying to sometimes exclude children from a classroom in the sense of a different way, but it wouldn't be recorded as an exclusion – that is my experience."

Assistant director for children's social care

In such circumstances, the fault for the breakdown tended to be attributed to the child and their needs rather than looking at whether or not the provision could be improved to maintain the child in an effective learning environment. There was a concern that where placements ended outside of formal processes (neither as an exclusion nor a managed move), there was not an opportunity to plan for the child and review their needs. There was also little evidence that the impact of the multiple changes on the child's sense of security and behaviour were understood.

Finding 10

Our in-depth analysis of the journeys into residential care of 12 children placed at Hesley's children's residential settings highlights key challenges in current provision for children with disabilities and complex health needs that limit their access to the right support at the right time.

7.11 Our overall analysis of the children's journeys suggests that the support available for parents of children with complex needs and disabilities is inconsistent and fragmented across different local authority and health care areas in England. In phase 2 of the review, we propose to examine the commissioning requirements for children with the most complex needs to ensure that they have access to the best provision to meet their needs in a timely way, drawing on the analysis and learning from the market study published by the Competition and Markets Authority in March 2022, which found that, as a result of problems in the way the placements market was operating, children were not consistently gaining access to placements that appropriately met their needs.[30] There is a major opportunity to improve the efficiency and effectiveness of commissioning arising from the statutory changes made to health and care commissioning brought about by the Health and Care Act 2022. This transferred accountability for safeguarding, children and young people with SEND and children in care from Clinical Commissioning Groups (CCGs) to Integrated Care Boards (ICBs) from 1st July 2022. We will look to incorporate the recent work undertaken for the independent review of children's social care and its proposals for transforming care.[31] We will also consider research evidence about alternatives to residential placements through such provision as specialist support services, family help, early diagnosis and preventative services and coordinated wraparound care.

30 Competition and Markets Authority (2022), Children's social care market study final report England Summary, paragraphs 18-21.

31 The Independent Review of Children's Social Care (2022). See in particular Chapter 5, Pp. 113-130.

8. Implications for the wider system: review phase 2

8.1 The purpose of phase 2 of the review is to learn from what happened to the children at Hesley's residential settings in Doncaster so that, in future, children with complex needs and disabilities are kept safe and thrive in residential schools registered as children's homes. We know of good practice and will be listening to the views of individuals and organisations to improve practice in the future. We will seek to identify any changes that need to be made to policy and practice to keep children safe and well in residential placements.

8.2 The focus of work in phase 2 will be structured around three key lines of enquiry:

1. What needs to happen to ensure the voices of children with complex health needs and disabilities are listened to and heard, and their rights are respected and upheld?
2. What are the respective roles of different professionals in keeping children with the most complex needs safe? What changes, if any, are required to improve their effectiveness?
3. What are the conditions for efficient and effective commissioning so that children with complex health can access the very best support to meet their needs in a timely way?

8.3 The review process will include:

- desktop research to identify best practice nationally and internationally
- preparation of practice briefings to include priorities for change in policy and practice
- structured engagement with stakeholders through national multi-agency round table events to 'test' our analysis

Our expectation is that the report on phase 2 of the review will make national recommendations for improvement and change and will be published in spring 2023.

9. Urgent action for assurance

9.1 We anticipate that there will be parents and carers with children in similar settings who will read this phase 1 report and be alarmed at what happened to the children at Fullerton House, Wilsic Hall and Wheatley House. OFSTED registration data shows us there are 69 establishments offering 1,793 places. While most children in residential special schools will be receiving a safe service, the level of concerns raised by this review means we should be ensuring that all children living in residential special schools registered as children's homes are receiving safe, quality placements. Parents and carers will demand reassurances that their children are safe from abuse.

9.2 Accordingly, the Panel has initiated urgent assurance action by DCSs and OFSTED, ahead of the publication of the phase 1 report, to:

- ensure that placing local authorities have an up-to-date view about the progress, care and safety of children with disabilities and complex health needs who are placed in residential special schools registered as children's homes
- ensure that, for all residential special schools registered as children's homes, any LADO referrals, complaints and concerns over the last three years relating to the workforce have been appropriately actioned
- ensure effective liaison between LADOs in 'host' local authorities with residential special schools registered as children's homes, and the LADOs in placing local authorities
- understand current workforce challenges in these settings

It is anticipated that these actions will be completed by the end of November 2022.

Urgent Action 1

- Directors of Children's Services are to ensure that Quality and Safety Reviews are completed for all children with complex needs and disabilities currently living within placements with the same registrations (i.e., residential specialist schools registered as children's homes) to ensure they are in safe, quality placements.

- This action should be led and overseen by the placing (i.e., home) local authority DCS. If a Review identifies concerns about the conduct of a member of the workforce, the placing local authority may need to share the concerns with the host Local Authority Designated Officer (LADO) if the threshold has been met.
- DCSs have been asked to provide an overview report on key findings and issues to both their local corporate parenting board and to local safeguarding partners, together with assurance that the Quality and Safety Reviews have been completed.
- DCSs have also asked to send a copy of their overview report on the Quality and Safety Reviews to the relevant DfE regional improvement support lead (RISL). The Phase 1 review has highlighted how information may be held locally but that it is also important to develop a fuller and more comprehensive picture of quality in these type of placements. This will also allow for regional and national assurance that these actions have been undertaken.

Urgent Action 2

In relation to children with disabilities and complex health needs who are looked after children and who are currently placed in residential specialist schools which are registered as children's homes, all Directors of Children's Services should ensure:

- That the host authority LADO for each individual establishment reviews all information on any LADO referrals, complaints and concerns over the last 3 years relating to the workforce in such establishments to ensure these have been appropriately actioned.
- The host authority LADO should then contact any local authorities who currently have children placed in the establishments in their area if there are any outstanding enquiries being carried out regarding staff employed in the home.

DCSs have been asked to confirm that urgent action two has been taken within the overview report that will be provided to the DfE Regional Improvement Support Lead on action one above.

Urgent Action 3

OFSTED to conduct an immediate analysis of their evidence around workforce sufficiency focusing on its suitability, training and support.

10. Conclusion

10.1 Our intention in the first phase of the review was to find out how the children came to be placed at one of these settings and what happened to them. These settings were regulated by OFSTED and operated as independent residential settings, funded through fees from the public purse. The conditions for abuse were allowed to flourish, and we have sought to find out how and why this happened.

10.2 Hesley's children's residential settings in Doncaster were these children's homes for the duration of their stays. They should have felt safe, happy and supported. Instead, their experiences at the settings were transformative and traumatic. Children far away from home, often with limited communication skills, were trapped in settings where systemic and sustained abuse was inflicted with no respite. As professionals familiar with serious harm, we have been shocked by what we have learnt. Children experienced repeated and dangerous physical restraints, were deprived of their liberty, were subjected to physical abuse as a form of discipline, and suffered bullying, taunting and excessive and inappropriate use of medication. Abuse and neglect flourished due to lack of oversight, limited professional curiosity and poorly exercised accountability which allowed the provider to take on a lead role, picking and choosing what was shared without challenge and painting a false reality. Ultimately, the voices of the children were not heard.

10.3 The individuals responsible for this harm and abuse are the subject of criminal investigations. While no system, however robust, can fully eliminate all risk of harm and abuse, those risks were exacerbated by wider systemic failings arising from inadequate leadership and management, poor quality training, support and supervision of the workforce, weak compliance with legal requirements, and regulatory failure.

10.4 The decision to place a child in a residential care setting is complex. It has to accommodate the wishes and emotional journeys of parents, the challenge of finding a suitable place, and the financial outlay from the public purse. What needs to drive this decision is a good and full understanding of the needs of the child and how well matched the setting is to meet those needs. The setting has to be both suitable at the point of placement and sustainable for the longer term, given the changing needs as the child develops and makes the transition to adulthood. Phase 2 will therefore explore critical issues relating to the sufficiency of provision and whether a different approach is required, building on the findings of the recently published independent review of children's social care.[32] In doing so, our recommendations will concentrate strongly and clearly on the improvements that must be secured nationally to help children with disabilities and complex needs access the very best care and support to which they have an unquestionable entitlement.

32 https://childrenssocialcare.independent-review.uk/

Appendices

Appendix 1. Terms of reference: review phase 1

The key lines of enquiry were:

- How were children placed at Fullerton House, Wilsic Hall and Wheatley House, and what procedures and practices were in place to ensure that they were safe and well?
- How was the quality of care for each child kept under review?
- How did concerns arise and what was the quality of the response?
- Is what happened to these children reflective of practice more generally and how could the safeguarding system be improved?
- In the light of the findings, identify any urgent action required to assure the safety and care of children placed in similar specialist settings.
- Identify key issues for further exploration and the development of national recommendations in Phase 2 of the review.

The review has begun with the children at the centre, and in phase 2 will examine broader lessons for the system. In this initial stage we needed to establish:

- What is the evidence telling us?
- What are the key issues and concerns?
- What is the urgent learning we can share with the sector to promote and protect children's safety and wellbeing?

Appendix 2. Questionnaire sent to home local authorities of children placed at the three settings

Framework for exemplar children's journeys: Pre- and during placement at Hesley Group

Identification of needs

What early learning and health checks took place?

- What did they report?
- Were other agencies subsequently involved?

When did physical and sensory health checks (e.g. sight and hearing) take place?

Had they received an annual health check?

When did they receive a formal diagnosis?

Were they on a waiting list for a diagnostic pathway?

- If so, how long had they been waiting?

Were they on the learning disability register?

Are there records of A&E attendance?

- If so, how many times and when?

Were they admitted to tier 4 inpatient care? Under what circumstances (e.g. under Mental Health Act)? (See additional questions below)

- If so, how many times?

Are there any records of periods out of school?

- If so, what were the reasons?
- Were any other agencies involved (e.g. health/social care)?

Are there any records of early exclusions?

- If so, at what age was the first exclusion?
- How many times has the child been excluded?

What was the child or young person's age at their first change of school?

How many times have they come to the attention of children's social care?

Assessments and plans

At what stages did the child or young person (and their family) receive social care involvement? (Assessment undertaken – this may also include early help assessments)

When was their first statutory education, health and care needs assessment and education, health and care plan?

Has there been historical social care involvement in the child or young person's family?

- When was their first assessment?
- When were they first allocated a social worker?

Have they been subject to a child in need plan and/or child protection plan?

- If so, under which category (neglect, emotional, physical, or sexual abuse)?

How long were they on the child in need plan and/or child protection plan?

When did the young person become looked after?

Is there evidence of involvement in decisions relating to their care and support?

- How were the young person's views, wishes and feelings explored and recorded?
- Is there a reasonable belief that they may lack capacity in relation to consenting to their care and support?
- Was a mental capacity assessment carried out?
- Is there evidence of best interest decisions?
- Is there evidence of lawful authorisations of deprivations of liberty?

By which route did the young person become looked after?

- Voluntary arrangement – under Section 20 of the Children Act 1989
- Care order
- Emergency protection order (then potentially subject to care proceedings; interim care order/care order)
- Police protection order (then potentially subject to care proceedings; interim care order/care order)
- A tribunal judgement

Support/treatment

Was there any early support intervention from education, health and care agencies, including any family support?

Did they access short break provision?

- If so, what type of short break provision (e.g. day, evening, overnight, weekend activities, in the child or young person's own home, the home of an approved carer, or in a residential or community setting)?

Where they were receiving any health support or treatment, this could include:

- a form of positive behaviour support therapy or similar
- physical, occupational, speech/language, sensory therapy
- using health commissioned short breaks
- specialist support from Child and Adolescent Mental Health Services
- support from the community learning disability team
- receiving personal health budget
- medication
- support from a dietician or nutritionist or other diet/nutrition support
- dental support or treatment
- family carer support – including the Healthy Parent Carer Programme

Was there a health element and/or social care element of an education, health and care plan or other form of multi-agency plan (child in need plan, child protection plan, looked-after child etc)?

- If so, what was it, and do we know if it actually delivered/happened?
- In the education, health and care plan what were the:
- outcomes sought?
- provision made?
- placement?

Was anything done to enable the child to experience success?

- If so, where and how as that achieved?
- Was it built on?

Visits and reviews

Did annual reviews take place in a timely way?

- Who attended?
- Any change of provision (as well as placement)?
- If so, was it genuinely responsive to the nature of the difficulties or was it just a matter of finding a different place for doing the same thing?

Across placements, how often were they visited and by whom?

What happened in the visits?

- Was the child seen?
- Was the child seen in private?
- If not, who else was present?

How often have they been visited by parents/family?

Were any concerns raised?

Additional questions for those placed from inpatient settings

Experience of inpatient/admissions avoidance

Was there a discharge plan?

Was the discharge plan followed up on?

Were they on the Dynamic Support Register?

- If so, what happened as a result?

Were there any care education and treatment reviews or local authority emergency protocol in advance of, or after admission?

Was there a risk management plan?

Health involvement while in inpatient settings

Was the clinical commissioning group (or NHS England) contributing to the cost of the placement?

Have any of the above health checks been carried out while they have been in the setting?

What is the health element of the education, health and care plan – is it being delivered?

Is there any involvement from Child and Adolescent Mental Health Services?

Is there any involvement from the learning disability autism team?

Were they being prescribed and administered medication?

- Any evidence this was reviewed?

Appendix 3. List of professionals involved in group interviews

Senior education, health and care plan co-ordinator (special educational needs team)

Allocated social worker

Team leader

Designated nurse for children in care

Head of service (0-25 service)

Assistant director for safeguarding and care planning

Group manager for the statutory assessment team

Team leader (central placements team)

Group manager (Children's Disability Service)

Safeguarding Children Partnership manager

Interim team manager (Children's Disability Service)

Designated doctor for looked-after children

Independent chair of the Safeguarding Children Partnership

Head of service (special education needs)

Head of service (quality improvement)

Deputy head of virtual school

Designated doctor for child safeguarding

Independent reviewing officer

Deputy designated nurse for looked after children and safeguarding

Advanced practitioner (children with disabilities team)

Independent reviewing officer service manager

Short breaks manager

Interim designated nurse for safeguarding

Interim service director (safeguarding and quality and improvement)

Personal advisor

Learning disability team lead (clinical commissioning group)

Interim service manager

Interim team manager (children with disabilities)

Education, health and care assessment and review team manager

Chief officer for children's social work

Head of service (child health and disability)

Service delivery manager (child health and disability team)

Children's continuing care team leader

Head of disabled children's service

Locality team leader

Assistant director for children's social care

Assistant director of education inclusion

Deputy chief nurse

Strategic manager (operations, adult social care)

Strategic manager (statutory special educational needs and disabilities team)

Operations manager (children with disabilities)

Accommodation and support team manager

Director of lifelong learning (education)

Senior manager (transitions team, adult social care)

Director for children's commissioning

Assistant director of learning disabilities and autism transition services (adult social care)

Education and inclusion service manager

Director for quality assurance and performance

Assistant director for inclusion and additional needs

Assistant director for special educational needs and disabilities and corporate parenting

Assistant director for children with disabilities

Appendix 4. The legal framework

The Children Act 1989 is the primary piece of legislation in relation to looked after children. It sets out the different pathways into care and the associated legal status of the children placed. In addition to the primary legislation, there are a series of pieces of statutory guidance, including:

- Working Together to Safeguard Children (2018)
- The Children Act 1989 guidance and regulations volume 2: care planning, placement and case review (2015)
- Visiting children in residential special schools and colleges (2017)

These set out the way in which duties towards disabled children and young people in residential settings should be carried out in practice, dependent on whether or not they are 'looked after'.

Legal status

All disabled children are defined as 'in need' under the Children Act 1989. The Act not only creates an assessment duty for individual children and young people, but also requires certain types of service and provision to be available to meet the needs of disabled children, including residential and foster care short breaks.[33]

In terms of legal status, there are several legal bases for a child being placed with a residential special school settings for disabled children and young people. Depending on the legal basis for placement, different considerations are relevant to understanding whether a child has 'looked after' status and the subsequent duties under a number of aspects of the Children Act 1989, including:

- Section 20 (3), Section 20(4) or Section 20(1)
- Section 31
- Section 85
- Section 86

There is a 'specific' duty on local authorities to safeguard and promote the welfare of the children they look after.

33 Disabled Children: A Legal Handbook (third edition)

Section 20

Where a child is 'looked after' voluntarily under Section 20 (i.e. with parental agreement), a local authority does not acquire parental responsibility. In those circumstances, responsibility remains with the child's mother or parents (Children Act 1989, Section 2). However, local authorities do have additional duties towards disabled children who are 'looked after', including in relation to accommodation and maintenance.

Where a child who is 'looked after' under Section 20 is in a 52-week residential special school placement, the full 'looked after' scheme is in place, rather than the modified scheme which applies in some circumstances due to the child being in receipt of overnight short breaks (see below).

Section 31

A child is described as being in care when a legal order is made (such as an interim or full care order), and the parents or those with parental responsibility may or may not have provided consent. An interim care order or full care order allows the local authority to determine future plans for the child. The local authority can also determine where the child should live.

In these circumstances, children are 'looked after'. This requires the local authority to provide accommodation, to maintain and safeguard, to promote welfare, and to give effect to or act in accordance with the other welfare responsibilities set out in the Children Act 1989.

Section 31 gives the local authority parental responsibility for the child and the power to determine the extent to which the child's parents and others with parental responsibility may exercise their responsibility, where this is necessary to safeguard or promote the child's welfare.

Sections 85 and 86

Sections 85 and 86 of the Children Act 1989 require that where children are provided with accommodation other than under the social care powers and duties (e.g. the local authority's education department) for a significant period (intended to be three months or more), the relevant children's services department must be notified.

Section 85 applies where children and young people are placed in residential education or care placements by health or local authority education services.

Section 86 applies where children or young people are placed in a residential care home or independent hospital.

None of the children in scope in our review were placed at Hesley's children's residential settings in Doncaster under sections 85 or 86 of the Children Act 1989.

Overnight short breaks

Although the legal framework applies to all children and young people, it is possible that some disabled children in receipt of short break support via overnight short breaks (either residential or family-based) may be 'looked after' under Section 20(4):

'A local authority may provide accommodation for any child within their area (even though a person who has parental responsibility for him is able to provide him with accommodation) if they consider that to do so would safeguard or promote the child's welfare.'[34]

It is also possible that the child becomes 'looked after' via the specifically enforceable duty under Section 20(1) when "a parent was 'immediately' prevented from providing a disabled child with suitable care and accommodation".[35]

In terms of establishing the legal status of a disabled child who is receiving overnight short breaks, the guidance[36] states that children whose welfare will be best safeguarded by becoming 'looked after' during residential short breaks include:

- children who have substantial packages of short breaks, sometimes in more than one setting
- children whose families have limited resources and may have difficulties supporting them or monitoring the quality of care while they are away from home

Disabled children who are 'looked after' by dint of their accessing short break provision overnight for more than 24 hours on a regular basis may be subject to the modified regulations for 'looked after' children where:

- no single placement is intended to last more than 17 days
- the total in one year does not exceed 75 days

This means that some disabled children and young people may have 'looked after' status under the modified scheme before entering a 52-week residential special school or college.

34 Children Act 1989 – Section 20(4)

35 Disabled Children: A Legal Handbook (third edition)

36 Ibid.

Pre-placement

Many of the disabled children and young people in scope of this review received placements in response to emergency or crisis situations which made planning more challenging. Despite this, there are a number of key requirements that local authorities must consider before placement[37], including:

- the identified placement should be the 'most appropriate placement available' that will 'best promote and safeguard the child's welfare'
- when deciding on the most appropriate placement, the local authority must 'give preference to' placement with a connected person, such as a relative or friend

The local authority must, as far as is reasonably practicable, ensure that the placement:

- is near the child's home within their communities
- does not disrupt education
- enables siblings to live together (where the siblings are also looked after)
- provides accommodation which is suitable to the child's needs if the child is disabled
- is within the local authority's area

In addition to the above considerations, the local authority will need to determine if the placement should be under the 'looked after' framework and progress with the relevant care planning requirements. There should be effective information sharing between all agencies, including children and young people and their family, to inform placement planning. Wherever possible, all parties, including the responsible authority, should be notified of the placement before the child is placed.

Where the placement is outside of the local authority's area and located considerably far away, it must be approved by the DCS.

37 See Children Act 1989 section 22c

Notification

When a decision has been made in relation the most appropriate placement for a child, and ideally before the child is placed, the placing (home) local authority must send a notification to a range of key people and agencies as set out in the Children Act 1989 guidance and regulations volume 2: care planning, placement and case reviews.[38]

Where a child is looked after, the allocated social worker in the home local authority has responsibility and all relevant parties should be informed and aware. However, this may not be the case where a child is placed via education or health, so there are requirements to notify the relevant agencies.

Under Section 85, where a child or young person is in a residential placement with education functions, the placing (home) authority is responsible for notifying the DCS of the local authority where the child is ordinarily resident.

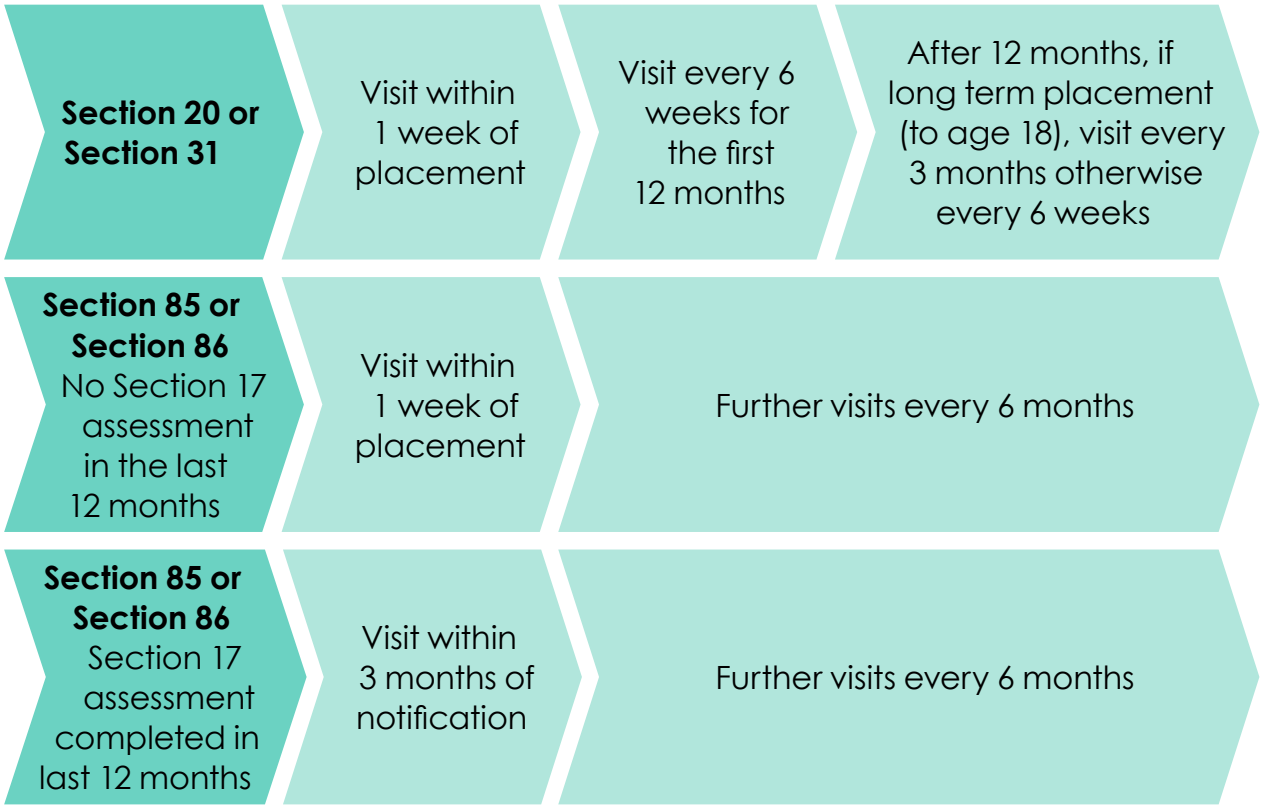
Under Section 86, where a child or young person is in a residential care home or independent hospital, the manager of the setting must notify the DCS of the local authority where it is located.

38 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1000549/The_Children_Act_1989_guidance_and_regulations_Volume_2_care_planning__placement_and_case_review.pdf

Reviews and visits

The requirements for reviews and visits for looked-after children are clearly set out in the Children Act 1989 guidance and regulations volume 2: care planning, placement and case reviews.[39]

There are a series of duties in relation to the timelines for review and visits to individual children and young people dependent on their legal status, as shown in the flowchart below devised by the review team from the relevant statutory guidance.



The responsible local authority must also make arrangements to visit under the following circumstances:

- whenever reasonably requested to do so by the child or young person
- if it believes that a visit is required in order to safeguard and promote the child or young person's welfare

39 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1000549/The_Children_Act_1989_guidance_and_regulations_Volume_2_care_planning__placement_and_case_review.pdf

The local authority should ensure that all children and young people have accessible means of requesting a visit. There is detailed guidance on the way visits should be carried out, their purpose and who should be in attendance, in relation to both children who do not have looked-after status and those who are looked after.[40] Visits to looked-after children have a number of key purposes as set out in guidance, including to:[41]

- support the development of a good relationship between the child and the social worker, which will enable the child to share their experiences, both positive and negative, within the placement
- provide an opportunity to talk to the child and to offer reassurance if they feel isolated and vulnerable while away from family and friends
- evaluate and monitor the achievement of actions and outcomes identified in the care and placement plan, and contribute to the review of the plan
- identify any difficulties that the child or carer may be experiencing, provide advice on appropriately responding to the child's behaviour, and identify where additional supports and services are needed
- monitor contact arrangements to identify how the child is responding to them and any additional support carers may need

Where children are not 'looked after', visits should:

- review the child alone in the placement unless they refuse
- consider how the placement is safeguarding the child and promoting their welfare and outcomes
- seek the views of parents and explore contact arrangements
- consider whether additional provision needs to be made
- send a report of the visit to the relevant local authority, child and family

40 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656849/Visiting_children_in_residential_special_schools_and_colleges.pdf

41 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1000549/The_Children_Act_1989_guidance_and_regulations_Volume_2_care_planning__placement_and_case_review.pdf

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