

## 1 Background and Concerns

The National Child Safeguarding Practice Review (CSPR) Panel undertook a two-phase review 'Safeguarding children with disabilities and complex needs in residential settings'. This followed the abuse and neglect experienced by a number of children in three residential settings run by the Hesley group in Doncaster. Phase 2 focused on national improvements needed to help children with disabilities/ complex health needs access the best care and support they are entitled to.

The Government published its response, accepted 2 of the Panel's recommendations and agreed in principle with the other 7. The 3 safeguarding partners in each area were required to consider the effectiveness of local arrangements in relation to children with disabilities and complex needs living in residential settings.

## 2 Key findings

- Leadership/ management inadequate - statutory requirements not met
- Voices children/ young adults not heard and their individual care plans not followed
- The settings demonstrated weakness in compliance with statutory reporting under Children's Homes Regulations 2015
- Major failings in operation of LADO function
- Inaccurate and inconsistent record keeping meant that OFSTED and placing authorities had a false picture of care

## 3 Key Learning

- Over reliance on residential settings to provide accurate information and lead the care planning & review
- Childrens presenting behaviour not recognised as signs/ symptoms abuse.
- Analysis of patterns concern/ information sharing across partners & LAs would have led to earlier identification and escalation.
- Unrecognised complexity of need, children had experienced trauma/adversity, but disability was the overwhelming focus

## 7 Further information

CSPR Panel Phase 1 report [Safeguarding children with disabilities in residential settings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674441/Safeguarding_children_with_disabilities_in_residential_settings_-_GOV.UK_(www.gov.uk).pdf)

CSPR Panel Phase 2 report [Safeguarding children with disabilities in residential settings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674441/Safeguarding_children_with_disabilities_in_residential_settings_-_GOV.UK_(www.gov.uk).pdf)

West Midlands Closed Culture webinar [UK Display - Widescreen \(16:9\) - 15s - 50% & OJF NATIONAL - Mixed Models v2 - Aug 2024 \(youtube.com\)](https://www.youtube.com/watch?v=RJ1IXisTirY&cbrd=1)

Government Response [Safeguarding children with disabilities in residential settings: government response - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674441/Safeguarding_children_with_disabilities_in_residential_settings_-_GOV.UK_(www.gov.uk).pdf)

Closed Culture webinar

<https://www.youtube.com/watch?v=RJ1IXisTirY&cbrd=1>  
[Closed cultures in social care: Guidance and questions to ask | Local Government Association](https://www.youtube.com/watch?v=RJ1IXisTirY&cbrd=1)

[Local government out of area placements guidance | Local Government Association](https://www.youtube.com/watch?v=RJ1IXisTirY&cbrd=1)

## 6 Next Steps

- Briefing to be used in team meetings/ supervision
- Ensure learning informs current practice
- Learn more about the review and findings and the danger of closed culture.
- Use the best practice principles within practice



## 4 Key Factor - Closed Culture

- One where unlikely many outsiders go in to
- Fewer external people to observe practice
- Staff stop seeing the situation the child is in
- Child afraid or unable to speak up and may not be heard

### Risk factors:

- There may be breaches of human rights
- Closed culture can exist within other areas too
- A poor culture can increase the risk of harm
- Concerns are less likely to be observed, reported, or considered and unchallenged.

## 5 Best Practice Principles

Ensure that all children have an accessible way of requesting a visit	The placing authority continues to lead on the review and planning process
Understand the child's voice/ lived experience. Listen to family concerns	Timely, high quality statutory visits/ reviews are critical and the IRO in monitoring this
Professionals need to be clear how to raise concerns with one another, and escalate, to ensure the safety and wellbeing of children	Ensure accessible opportunities for children to participate in reviews and care planning and access to an advocate
Question/ challenge poor practice, missing/ inaccurate information/ record keeping that fails to meet care homes quality standards	Establish clear lines of communication across the host and placing local authority
Be clear of threshold for reporting to LADO	Seek independent sources of information