Safeguarding children with disabilities and complex health needs in residential settings: Phase 1 and 2 reports
Child Safeguarding Practice Review Panel
Briefing

Introduction and background

Phase 1 Report

The Safeguarding children with disabilities and complex health needs in residential settings: Phase 1 report was published in October 2022 and sets out the findings from phase one of the national review into the experiences of 108 children placed from 55 local authorities at three independent residential settings operated by the Hesley Group in Doncaster (Fullerton House, Wilsic Hall and Wheatley House). All of these children had disabilities and complex health needs. The review was formally launched in January 2022 following Doncaster Council/Safeguarding Children Partnership initiating a complex abuse investigation (Operation Lemur Alpha) in response to twelve whistleblowing allegations of abuse and concerns for children placed at these settings.

The review has uncovered a catalogue of abuse and serious harm of some of the most vulnerable children in our society. Phase two of the review will focus on the changes needed to the wider system so these most vulnerable children live in safe, loving and positive environments and is due for publication in spring 2023.

A complex criminal investigation is being progressed by South Yorkshire Police into what happened to these children. In light of the seriousness of the review's findings this report has been published to learn what changes to safeguarding practice are needed. In addition, prior to this report the Panel requested that Directors of Children's Services (DCSs) and OFSTED undertake urgent assurance action about all children placed in similar types of provision. DCSs across England are overseeing quality and safety reviews of all children placed in similar types of provision to provide reassurance that such settings meet children's needs and to address any concerns. These actions will enable local authorities, the Department for Education (DfE) and the Panel to assess the extent to which provision is meeting the needs of these vulnerable children.[1]

Review methodology

The Child Safeguarding Practice Review Panel (hereafter referred to as the Panel) commissioned Dame Christine Lenehan, Strategic Director at the National Children's Bureau and Director of the

[1] Overview reports on the two urgent actions for DCSs have been requested to be completed by the end of November and to be submitted to the DfE regional leads by 23 December 2022. The North Lincolnshire overview report will be submitted to the safeguarding partners and Corporate Parenting Board at the Panel's request, ahead of its submission to the DfE's regional lead.

Council for Disabled Children, as the lead reviewer for this work. The underpinning values for the review are informed by the principles of the United Nations Convention on the Rights of the Child. 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. Despite these constraints the review has identified urgent assurance action and enabled dissemination of important national learning.

The review period in scope is January 2018 to March 2021. The first stage of the review's analysis was to collate data on the 108 children identified as in scope under Operation Lemur Alpha including data requested from questionnaires completed by home local authorities for each child.

Operation Lemur Alpha

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.

Impact of COVID-19

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.

The findings

Evidence from the Operation Lemur Alpha investigation and the review's analysis indicates that children placed in Hesley's children's residential settings experienced sustained, significant abuse and harm over an extended period of time. This included physical abuse and violence, neglect, emotional abuse, sexual harm, unmet medical needs and misused and maladministered medication.

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, the review 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 wishes and feelings of the children were not routinely sought. There was minimal evidence of training for staff in advanced skills in engaging with individuals who struggled to communicate, and staff did not respond appropriately to allegations from the children against staff members.

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.

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. 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.

Finding 2
Placement far from home increased the children's vulnerability.

Evidence from the Operation Lemur Alpha investigation and the review's 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.

Finding 3
Some children were placed at the settings inappropriately

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 which 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'. There must be clear procedures for referring child protection concerns and arrangements for dealing with allegations concerning staff.

In practice, the Hesley Group 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. The complex abuse investigation 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.

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.

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.

The Hesley Group experienced major challenges regarding staff recruitment and retention. 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.

Evidence gathered 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.

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.

There were many occasions that should have triggered an escalation of concerns about the provision at the settings. There was evidence of poor quality record keeping and storage of the children's records at the three settings that was not in line with the Children's Homes (England) Regulations 2015. Operation Lemur Alpha has raised concerns about the under-reporting of serious incidents to OFSTED and the placing local authorities.

There were periods when the registered person had not completed the Regulation 45 review in a timely way and there was limited evidence of this being used as a tool for self-evaluation and practice improvement. There was evidence to suggest that the independent persons appointed at Hesley did not always have the necessary impartiality to provide critical scrutiny during their Regulation 44 visits and some reports appear to be over-optimistic.

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.

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.

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.

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.

From 2018, there had been a significant and increasing number of allegations reported to the LADO against staff at Hesley. An independent review into the effectiveness of the LADO function in Doncaster found that poor work by the LADO up to 2020 meant that allegations were not investigated to a satisfactory standard, leaving children not adequately considered or safeguarded.

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.

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'.

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.

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.

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. Often those placements ended outside formal processes, with no opportunity to plan for the child and review their needs.

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.

Implications for the wider system: review phase 2
The focus of work in phase 2 will be structured around three 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?

Urgent action for assurance
The Panel 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

The individuals responsible for the harm and abuse of children placed with the Hesley Group 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.

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 at the point of placement and be sustainable for the longer term including during the transition to adulthood. .

Phase 2 report

The phase 2 report explored critical issues relating to the sufficiency of provision to determine whether a different approach is required, building on the findings of the independent review of children's social care. The recommendations from the review concentrated strongly 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.

Government response

On the 18 December 2023 the Government published a response to the national Panel's recommendations contained in their phase 2 report. The Government agreed with two of the nine recommendations, as outlined below, and agreed with the remaining seven recommendations in principle:

- Recommendation One: All children with disabilities and complex health needs in residential settings should have access to independently commissioned, non-instructed advocacy from advocates with specialist training to actively safeguard the children and respond to their communication and other needs.
- Recommendation Two: Local and sub-regional initiatives to improve the quality and range of provision in the community and in schools for children with disabilities and complex health needs should be priorities for inclusion in the government's pathfinder programs in children's social care and SEND.

  A cross ministerial letter was sent to the Chief Executives of the Local Authorities, Integrated Care Boards, Chief Constables of the Police, copied to all Directors of Children's Services on 18 December 2023, alongside the Government's response to the Child Safeguarding Practice Review Panel report. The Government recognises that the statutory safeguarding partners will consider the effectiveness of their arrangements in relation to children with disabilities and complex care needs living in residential settings on a regular basis.

  In undertaking such reviews, the Government have identified a list of considerations for the safeguarding partners to assure themselves against and / or plan further actions.

A benchmarking matrix for the North East Lincolnshire Safeguarding Children's Partnership (SCP) has been undertaken as our local response to the areas for consideration and will be kept under review until completion.

Safeguarding children with disabilities and complex health needs in residential settings: government response (publishing.service.gov.uk)