THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL

Briefing note for child protection professionals across England

This short briefing note aims summarises the key learning points from the independent Child Safeguarding Practice Review Panel's national review into safeguarding children with disabilities and complex heath needs in residential settings. The settings were residential special schools registered as children's homes operated by the Hesley Group. It outlines the context of the systematic and sustained abuse suffered by a large number of children and considers the wider systemic issues that need to be addressed.

The briefing note also sets out national recommendations for improving the provision for this specific group of children across England, and actions for local safeguarding partners. Read the full review report here: https://www.gov.uk/government/publications/safeguarding-children-with-disabilities-in-residential-settings

About the national review

Phase 1

The national review was conducted in two phases. Phase 1 was published on 26 October 2022 and followed a direct request from the Doncaster Safeguarding Children Partnership that the Panel undertake a national review into allegations of abuse against over 100 children placed in three residential special schools registered as children's homes (located in Doncaster and run by the Hesley Group).

The review found that:

- The children experienced significant harm and abuse – their voices were not heard.
- The leadership and management at the provision were inadequate with a "closed culture" that gave rise to poor practice and misconduct by care staff.
- The quality of care for the children was affected by high rates of vacancies and staff turnover, poor quality training, support and supervision.
- There was evidence of limited impact of quality assurance by the provider and placing local authorities, and by Ofsted at the regulator.
- There was a failing in the function of the local authority designated officer (LADO) role in Doncaster reflecting wider national concerns about the effectiveness of the LADO function generally and the responsibilities of "host" local authorities in relation to residential provision in their area.

Furthermore, as part of Phase 1, the Panel carried out an in-depth analysis of the children's journeys into residential care. This analysis highlighted key challenges in current provision that limited the children's access to the right support at the right time. The

evidence showed that the needs of some children could have been met through support in the community rather than a 52-week residential placement.

As a result of the Phase 1 review, the Panel asked Directors of Children's Services in England to undertake actions aimed at providing immediate assurance about the welfare and safety of all children in similar settings.

Phase 2

Phase 2 of the review was published on 20 April 2023 and it draws on the learning from what happened to the children at Hesley-Doncaster to set out an ambitious case for change in the quality, oversight and regulation of all residential settings for children with disabilities and complex health needs.

It explores:

- What needs to happen to ensure the voices of children with complex health needs and disabilities are listened to and heard, and that their rights are respected and upheld.

- The respective roles of different professions and agencies in keeping children with the most complex needs safe.

- The conditions for efficient and effective commissioning so that children with disabilities and complex health needs can access the best support to meet their needs in a timely way.

It found that we need to:

- improve the quality of leadership and safeguarding culture in residential settings.
- develop the skills of the workforce to enable children's communication and respond appropriately and effectively to behaviour that challenges.
- develop a framework for advocacy for children with disabilities and complex health needs.
- improve the engagement of, and support for, parents who 'speak on behalf of the child', including families from ethnic minorities.
- ensure that the support for Black and minoritised children with disabilities and complex health needs is respectful of, and appropriate to, their culture and identity.

What can we learn from what happened at the Hesley provision in Doncaster?

In analysing what happened at the Hesley provision in Doncaster, the review identified a set of issues which hindered professionals' understanding of how well and safe the children were in their placements. These include:

- The lack of a formal process for information sharing and triangulation of information meant that it was difficult to build up an understanding of the overall situation and the heightening levels of risk to children's safety.

- The importance of face-to-face statutory visits by social workers, independent reviewing officers and health commissioners. There must be greater curiosity and challenge at those visits to recognise inherent safeguarding risks. Practitioners need the requisite skills to communicate with children with disabilities, complex needs and behaviour that challenges.

- Practice issues relating to the appropriate use of physical restraints and restrictive interventions and their authorisation were not well understood by practitioners in local authorities and residential settings. We consider that there is an urgent need for high quality training to ensure that practitioners in local authorities, health services and residential settings understand the requirements for legally compliant practice in relation to physical restraints and restrictive intervention.

- Parents contributing to our review stressed the importance that every child placed in a residential setting has a named keyworker in the staff team based at the provision, who is trained and supported in the appropriate communication skills and able to provide a consistent and trusted relationship with the child. The effectiveness of this keyworker role is highly dependent on the quality of leadership in the setting.

What were the wider systemic issues affecting practice with this group of children?

- **Voice of the child** – Staff working with this group of children do not consistently have the requisite skills for recognising and responding to the different communication styles and behaviours of different children. There is also evidence that too often children living away from home have limited access to independent advocacy to enable support their voice and experiences being heard and understood.

- **Shortage of suitable placements -** There is a general shortage of appropriate residential placements for children with complex health needs and disabilities. This often leads to children being placed considerable distances from home which increases their vulnerability. Some children could have their needs met without a residential placement and this is reflected in one of the key recommendations of our review.

- **Support for leadership and workforce development** - High staff turnover, "closed cultures" and a lack of openness to external scrutiny and challenge were all evidenced in what happened in Hesley settings.

- **Quality assurance and regulation** – There was an over-reliance on reports from providers and lack of challenge and triangulation with other information. There was a lack of consistency in the approach of LADOs in different local authority areas.

We have set out below some questions that you might want to reflect upon as a practitioner either individually, as part of supervision, or as a group:

Learning from the review

1. What are the key lessons in this national review for your organisation and your practice, including working with other agencies?

2. What learning will you take forward from the quality and safety reviews undertaken by local authorities in summer 2022?

Working with children and families

3. How does your practice need to change so that the needs, voices and experiences of children with disabilities and complex needs are better addressed? How well are the specific needs of Black and minoritized children understood? Do children have good access to independent advocacy?

4. How well do you seek the views of parents, carers and others to know what is happening to children living in residential settings?

Assurance and oversight

5. What assurances will you be seeking from providers who are caring for children with disabilities and complex health needs? Is there good understanding of issues about the appropriate use of physical restraints, restrictive interventions and their authorisation?

6. If, through visits or other contacts with children in residential settings, you identify evidence of abuse, neglect or poor practice, are you confident of how voicing concerns or taking forward a complaint?

National recommendations

Recommendation 1: All children with disabilities and complex health needs should have access to independently commissioned, non-instructed advocacy from advocates with specialist training to actively safeguard children and respond to their communication and other needs.

Recommendation 2: Where an admission to a residential placement for 38 weeks or more is being considered, children, young people and their parents should have access to advice and support through their jointly commissioned and suitably resourced local Special Educational Needs and Disability Information Advice and Support Service, with allocation of a 'navigator' to work with the family where this is identified as being necessary.

Recommendation 3: Local authorities and ICBs should be required in statutory guidance developed by the Department for Education and NHS England to jointly commission safe, sufficient and appropriate provision for children with disabilities and complex health needs aligned with local inclusion plans and planning for care through Regional Care Cooperatives.

Recommendation 4: The DfE, DHSC and NHS England should co-ordinate a support programme for commissioners in local authorities and ICBs, focusing on improvements in forecasting, procurement and market shaping.

Recommendation 5: 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 programmes in children's social care and SEND.

Recommendation 6: The government should commission the development of an integrated strategy for the children's workforce in residential settings, to include: leadership development, workforce standards and training.

Recommendation 7: National leadership and investment by providers is urgently required to address the longstanding challenges in recruiting, retaining and developing a skilled workforce in residential settings.

Recommendation 8: Systems for the early identification of safeguarding risks in residential settings should be strengthened through an enhanced role for host local authorities and ICBs in the oversight of residential settings in their area.

Recommendation 9: The DfE and DHSC should (a) review and revise the regulatory framework for residential settings to reduce complexity and improve the impact of the current arrangements for monitoring, quality assurance and oversight; (b) take immediate steps to establish arrangements for joint inspection by Ofsted and CQC of residential settings for children with disabilities and complex health needs.

Supplementary recommendations

These are recommendations to be taken forward through national implementation plans or local partnerships.

1. To ensure that practitioners understand the requirements for legally compliant practice in relation to Deprivation of Liberty Safeguards local authorities, health services and residential settings should review their current systems, procedures and practice to determine their readiness for meeting the requirements under this framework.

2. The specification for the Regional Care Cooperative pathfinders should include measures to improve commissioning for children with disabilities and complex health needs.

3. The Families First for Children pathfinders should include programmes focused specifically on the development of integrated provision in the community and in schools for children with disabilities and complex health needs.

4. All children with disabilities and complex health needs who are on a pathway for admission to residential placement longer than 38 weeks per year should be part of a Care, Education and Treatment Review process. No decision should be made without multi-agency agreement and commitment.

5. To assist the understanding of all staff, statutory guidance about the inherent risks from ‘closed cultures’ should be included in ‘Working Together to Safeguard Children’ and ‘Keeping Children Safe in Education’.

6. Practice leadership should form the basis for a national programme of leadership development for leaders and senior managers in residential settings for children and young people.

7. A SEND practice guide for practitioners working with children with disabilities and complex health needs should be one of the first three SEND practice guides produced under the SEND/AP Improvement Plan.

8. The process for developing national SEND standards should be aligned with the work already underway relating to standards in children’s social care so that they are completed in a timely way for residential special schools as well as children’s homes.