# 7 Minute Briefing: Safeguarding Children with Disabilities in residential care homes – National Review

Phase One - February 2023

## 1. Background

- On 5th March 21 Doncaster Council initiated a complex abuse investigation into 3 specialist, independent, residential settings run by the Hesley Group, in response to whistle blowing referrals
- OFSTED had received a number of complaints regarding the settings, dating back to 2015
- Significant numbers of allegations had also been reported to the LADO
- Investigators identified a *catalogue of abuse and serious harm to the most vulnerable in society* and South Yorkshire Police instigated a complex criminal investigation
- In January 2022 a national review was launched due to the seriousness of the concerns and number of authorities involved

## 2. The Children & Young Adults

- The experiences of 108 children who were placed in the settings between 1st Jan 2018 – 21stMarch 2021, from 55 Local Authorities, were reviewed
- All children had disabilities and complex health needs, including autism (82%), learning disabilities (76%), mental health difficulties such as anxiety, obsessive compulsive disorder, bipolar disorder and attention deficit hyperactivity disorder (25%)
- All children had an EHCP (Education Health & Care Plan)
- The children functioned significantly below chronological age and displayed behaviour that challenged.

## 3. Findings

- Children placed in Hesley's children's residential settings experienced sustained and significant abuse and harm – physical and emotional abuse, neglect, misadministration of medication, inappropriate use of restraint
- The voices of children and young adults were not heard & their individual care plans not followed
- Placement far from home increased the children's vulnerability
- Some children were placed at the settings inappropriately
- Leadership & management was inadequate and failed to meet statutory requirements
- High rates of staff turnover, poor quality training and supervision, were significant factors affecting the quality of care

## 4. Findings continued…

- The settings demonstrated weakness in their compliance with statutory reporting requirements under the Children's Home (England) Regulations 2015.
- Inaccurate & inconsistent record keeping and reporting by the settings meant that OFSTED and placing authorities had a false picture of care
- There were major failings in the operation of the LADO function
- Intelligence available to OFSTED was not bought together with enough rigour to identify risk and escalate intervention earlier
- 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

## 5. Key Learning:

- There is an over reliance on residential settings to provide accurate information and lead the care planning & review
- Behaviour that challenges was 'explained away' as the impact of the pandemic or part of the childs complex needs and not recognised as signs and symptoms of child abuse
- Timely, high quality statutory visits and reviews are of critical importance. The role of the IRO is key in monitoring this
- Analysis of patterns of concern and information sharing across partners and local authorities would have led to earlier identification and escalation
- The Childs voice and daily lived experience was not understood by the professionals supporting them and their families

## 6. Key Learning continued…

- There was an unrecognised complexity of need – children had experienced trauma/adversity but disability was the overwhelming focus
- There is a lack of settings to support children with complex needs, meaning inappropriate placements were made – commissioning arrangements to be reviewed
- The Settings offering care 'packages' (ie education & health support) leave little room of external oversight and scrutiny
- Professionals need to be clear in how to raise concerns with one another, as well as escalate, to ensure the safety and wellbeing of children

## 7. Must Dos:

- Ensure that all children have an accessible way of requesting a visit
- Ensure accessible opportunities for children to participate in reviews and care planning & access to an advocate
- Recognise that behaviour is a form of communication and ensure professional curiosity and challenge is robust and ongoing in practice
- Listen to the concerns of family members
- The placing authority continues to lead on the review and planning process
- Seek independent sources of information
- Question & challenge poor practice, missing or inaccurate information and record keeping that fails to meet care homes quality standards and statutory regulations
- Establish clear lines of communication across the host and placing local authority
- Be clear regarding threshold for reporting to LADO