Corporate Parenting Panel

Date: Monday 16 January 2023
Time: 10.00 am
Venue: Shire Hall, Warwick (Committee Room 2)

Membership

Councillor Jeff Morgan (Chair)
Councillor Peter Gilbert
Councillor Caroline Phillips
Councillor Marian Humphreys
Councillor Penny-Anne O'Donnell
Councillor Jerry Roodhouse

Items on the agenda: -

1. General

(1) Apologies

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

(3) Minutes of the previous meeting 5 - 10

2. Performance Data 11 - 12

3. Warwickshire Response to the National Review Children with Disabilities and Complex Needs 13 - 34

4. Outline for the Corporate Parenting Panel Road shows

Verbal update to be provided to the Panel by Sharon Shaw, Service Manager for Corporate Parenting Service,

5. Development of the Work Programme and Items on the Forward Plan 35 - 38

Items from the Forward Plan relevant to the remit of the Panel.

6. Any Other Business

7. Date of Next Meeting

The next meeting will be held on 27th March 2023

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

Disclaimers

Disclosures of Pecuniary and Non-Pecuniary Interests
Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. Any changes to matters registered or new matters that require to be registered must be notified to the Monitoring Officer as soon as practicable after they arise.

A member attending a meeting where a matter arises in which they have a disclosable pecuniary interest must (unless they have a dispensation):

- Declare the interest if they have not already registered it
- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests relevant to the agenda should be declared at the commencement of the meeting.

The public reports referred to are available on the Warwickshire Web https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

COVID-19 Pandemic

Any member or officer of the Council or any person attending this meeting must inform Democratic Services if within a week of the meeting they discover they have COVID-19 or have been in close proximity to anyone found to have COVID-19.

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Corporate Parenting Panel

Monday 28 November 2022

Minutes

Attendance

Committee Members

Councillor Jeff Morgan (Chair)
Councillor Marian Humphreys
Councillor Penny-Anne O'Donnell
Councillor Jerry Roodhouse

Officers

Chris Baird, Interim AD for Education
Helen Barnsley, Senior Democratic Services Officer
Molly Boneham, Social Care Worker Level 1b
Amy Bridgewater-Carnall, Senior Democratic Services Officer
John Coleman, Assistant Director - Children and Families
Marie Dionsi, Family Support Worker
Ian Donnachie, Apprentice (Children in Care 14-18)
Deborah Mcgarvey, Non-Social Work Operational Team Leader
Nigel Minns, Strategic Director for People
Deena Moorey, Virtual School Head
Liss Phillips, Family Support Worker
Sharon Shaw, Service Manager - Corporate Parenting Service
Jo Smith, Delivery Lead Social Work Operations Manager
Umar Teerab, Family Support Worker

Others Present

Angela Richardson, Designated Nurse – Children in Care

1. General

(1) Apologies

Apologies were received from Councillor Pete Gilbert and Councillor Caroline Phillips.

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

None

(3) Minutes of the previous meeting

In relation to the second paragraph of item 3 of the minutes from the 12th October 2022, the follow changes were agreed –

- In response to Councillor Caroline Philipps, Sharon Shaw said that the unaccompanied asylum seekers placed in the hotels were coming from Sudan, Afghanistan, Iran, Iraq and Albania. They are placed in hotels because there is no other accommodation available. It was believed that there was an increase from children from Albania because they disappear from the hotels they are in, so more are trafficked.

In relation to item 6 of the minutes from the 12th October 2022, it was confirmed that the addition to the work programme in relation to Governance for Child in Care would be a flow chart and not a full report.

Following the above changes the minutes were agreed as a true and accurate record. There were no matters arising.

2. CiCC & Voice, Influence and Change Team Update

Ian Donnachie, Apprentice (Children in Care 14 – 18 years) updated the panel on the Apprentice Appreciation Day which was held on the 6th October. This was an event that allowed care experienced apprentices to provide feedback on their role and offer ways that it could be improved for future cohorts. The panel noted that the session had allowed apprentices to highlight that in some cases, based on their own experience, the role could be close to home. As a result, managers may benefit from additional support so that they have a better understanding of any potential triggering areas for new apprentices.

Marie Dionisi, Family Support Worker provided an update on the relaunch of the Children in Care Council (CiCC) which was held on the 13th October 2022. It was noted that 13 young people attended aged from 11 to 17 years old and that it was an opportunity for them to find out more about what being part of the CiCC involved. Young people were also given the chance to mention areas that they would like included in future agendas of the CiCC; such as more family time, time with siblings, self-harm and the chance to meet carers before they moved in with them. The panel was pleased to note that feedback had been very positive.

Following a question from the Chair, it was confirmed that the most important issues for young people was mental health. It was also confirmed that in January 2023, there will be a meeting with MIND representatives to discuss how to develop better mental health with young people, including wellbeing and self-harm.

Councillor Jerry Roodhouse asked what officers were trying to achieve; acknowledging that mental health and wellbeing is very different for everyone. Marie Dionisi agreed with Councillor Roodhouse and added that the CiCC is about creating a place for young people to come together and voice their concerns in a safe community where everyone comes together. Angela Richardson, Designated Nurse – Children in Care added that developmental trauma is something that young people in care face and that has a significant impact on them and that it is something that doesn't necessarily fit the mental health hat. The panel noted that work is

underway in relation to a strategy to address this and working with young people to develop this.

Councillor Penny-Anne O'Donnell asked how much information a child receives in relation to their foster carers; suggesting that information about the proposed length of their stay and meeting them before the placement starts could strengthen their resilience and mental health.

Nigel Minns, Strategic Director for People confirmed that the national picture in relation to concerns about young people's mental health is reflected in Warwickshire. It was noted that mental health support teams in schools are making a real difference and it was agreed that feedback will be bought to a future meeting of the panel.

Liss Phillips, Family Support Worker gave an update on the Care Leavers Forum and confirmed the plans for 2023 which include looking at rights and entitlements of young people. The forum completed a review of the last 12 months and the panel was pleased to note the positive feedback received.

Umar Teerab, Family Support Worker ended the item with an update on the football team. The panel was pleased to note that this is still very popular and that other local authorities have shown an interest in setting up their own teams. It was also noted that the police have a team that play regularly and that the fire service were also interested in setting up a team to join in.

3. Performance Data

Sharon Shaw, Service Manager - Corporate Parenting Service introduced the item and provided clarification on the data relating to short term placements. It was noted that this is a key area that officers are currently working on. Officers have recently met with colleagues from Telford and Wrekin who have been doing well in this area but who are also currently facing issues.

Following a question from Councillor Jerry Roodhouse, it was confirmed that short term placements are a national issue. Sharon Shaw confirmed that residential homes are closing and that there are no beds in secure accommodation (always a last resort for WCC). Foster carers are raising concerns that they are not being paid enough in the cost-of-living crisis so are choosing not to take any young people at the moment. John Coleman, Assistant Director - Children and Families confirmed that it is a very complex issue, adding that many young people have really complex mental health needs. It was agreed that an item focusing on the stability of placements is presented at a future panel meeting.

In relation to missing episodes, Sharon Shaw confirmed that the data for Warwickshire remains stable. Clarification was given to the panel that missing does not mean that officers do not know where a young person is. There is not a pattern of long term "missing" in Warwickshire. The example was given that if a young person stays out longer than expected, they will be recorded as missing if they are out past 12am. Another example would be if a young person has left a foster placement to go and see family members. The panel was pleased to see that since 2020, the number of missing episodes in Warwickshire has reduced.

The panel noted that in relation to young unaccompanied asylum seekers, there was no current data on how Warwickshire compares to statistical neighbours. Officers confirmed that there are working groups in place and that in the future there would be some data that could be presented to the panel.

4. Virtual School - Autumn 2022 Report

Deena Moorey, Virtual School Head presented the report to the panel confirming that the information related to the previous summer term (2022). It was confirmed that virtual school conferences have now returned to being face-to-face as well as training sessions. Attendees agree that being face-to-face makes a big different. It was noted that the numbers attending both conferences and training sessions have increased.
It was confirmed that there will a focus on ensuring that young people not in education, employment or training (NEET) attend their reviews. The work is proving to be very positive.

Training has been completed in order to fully understand what it is like to be a young person with a social worker. The training has been completed in all Bedworth schools and is underway in all the Nuneaton Schools which means that over 1000 staff will have received the training.

The panel noted that post-16 funding had been received and that there is a comprehensive training programme worked out. Warwickshire is working with the North Warwickshire College, South Leicestershire College and the Warwickshire College Group.

It was confirmed that there is an area of concern in relation to some young people who are struggling to return to school full time after the pandemic. The overall attendance is lower than the national figure but it is higher in primary schools.

It was confirmed that there are some staff who are still struggling to support children who have previously been in care and it was agreed that more training is needed to support staff. It was noted that this is an issue across the county and not just in one particular area. It is also a national issue.

5. SGO Policy Impact and Report

Joanna Smith, Delivery Lead Social Work Operations Manager presented the report to the panel in relation to Special Guardianship Orders (SGO).

The panel noted that there are now three full times workers in the SGO team who have full caseloads. The children and carers with SGOs in place are all benefiting and getting the care and support that they need.

There has been in increase in the number of families applying for and SGO and the service is expanding to reflect this and officers are now reaching out to families considering an SGO.

The panel noted that work to improved data collection is now underway.

The Chair asked for clarification on the difference between fostering or adoption and an SGO. It was confirmed that an SGO puts the family first and will look at ways to keep a child/young person with a family member. Adoption removes all responsibility from parents.

Following a question from the Chair, it was confirmed that, in relation to payment for the carers who have an SGO, an assessment is carried out to decide if (further) financial support is needed.

6. Development of the Work Programme for 2023/2024

The updated work programme was agreed by the Panel.

It was also agreed that from January 2023, all meetings would be held in Shire Hall rather than via teams. For those who are unable to attend the meeting in person, the option of joining via the hybrid technology would be offered.

8. Any Other Business

None

9. Date of Next Meeting

The next meeting will be held on 16th January 2023 at 10am.

The meeting will be held in Committee Room 2, Shire Hall, Warwick.

The meeting rose at 10.51

…….
Chair

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Corporate Parenting Panel

(as at 31st December 2022)

806 Children in Care

A decrease of **17 Children in Care** since November 2022

No. Children in Care - Monthly trend

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
ALL CiC (**Including** Asylum Seekers)	819	- 5	+ 2	+ 8	- 1	-17	806
ALL CiC (Excluding Asylum Seekers)	730	- 8	- 14	+ 3	- 3	-15	693

At 31 December 2022, Warwickshire's Children in Care population decreased by 17 to 806, whilst the no. of CiC excluding asylum seekers decreased by 15 to 693.

670 CiC target for 2022/23

Children in Care Placement Type

WCC Foster Carer (inc Family and Friends carers)

332 children (41.2%); which is an increase of 1 child on the previous month end.

Placed for Adoption

21 children (2.6%) of all CIC at 30 November; a decrease of 2 on the previous month end.

Agency Foster Carer

181 CIC (22.5%); a decrease of 1 children since 30/11/2022

Residential Establishment

79 children (9.8%); a decrease of 1 child since 30/11/2022

Legal Status of Children in Care as at 31 December 2022

52.5% (423) of CiC are on a **Full Care Order**; this is an increase of 2 children since 30/11/2022

13.0% (105) of CiC are on an **Interim Care Order**; this is a decrease of 11 children since the previous month end.

4.8% (39) of CiC are on a **Placement Order**; this is a decrease of 2 children since 30/11/2022.

29.4% (237) of CiC are subject to **S20 Accommodation**; this is an decrease of 5 children) since 30th November 2022.

Leaving Care Activity Status

As at 31 December 2022, of those Relevant and Former Relevant Care Leavers (aged 16 - 21) ...

- **79.3%** had a contact within the last 8 weeks
- **75.5%** were in suitable accomm odation
- **46.8%** were in EET (Employment, Education & Training)

CiC out of county

as at 31st December 2022

21.6%

(**174**) of CiC were placed outside the LA boundary and more than 20 miles from where they used to live

NB. Please note that this is a quarterly measure

CiC 'Missing' or 'Away from placement without authorisation'

24 children in care were missing (52 missing episodes)

During December 2022 there were **52 episodes** of a child missing or away from their placement without authorisation. This related to **24 individual children** with **12 children** having multiple missing episodes during the month.

Gender

61.8% (498) Male

38.0% (306) Female

2 'Indeterminate'

Ethnicity

1/4 (26.4%) of Children in Care (Including Asylum Seekers) are **Minority Ethnic (217)**;

73.6% (593) are of White ethnicity

Allocated Team

14% (113) of Children in Care are Unaccompanied Asylum Seekers

7.4% (60) are allocated to the Children with Disability teams

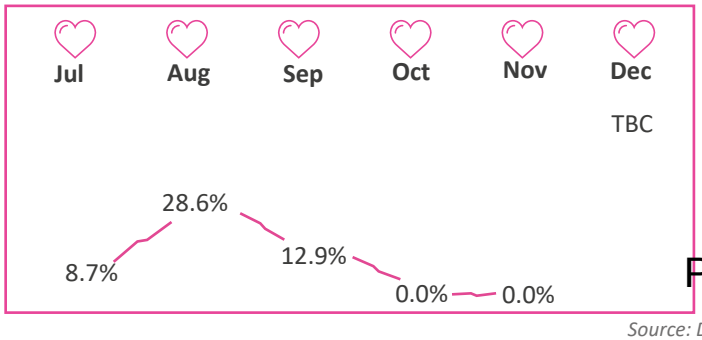
25.4% (205) are allocated to the CiC 14-18 Years Team

90.0% of Children in Care at 31 December 2022 have had a '**completed**' health assessment in the last 12 months

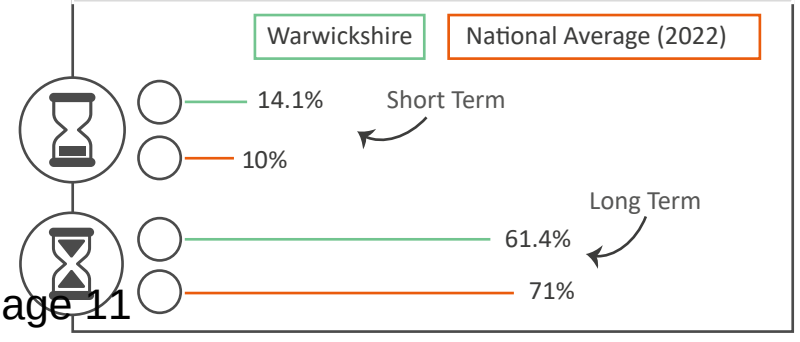
Age breakdown of the 806 children

2.7% (22)	14.6% (118)	16.4% (132)	33.9% (273	32.4% (261)
0 years old	aged 1 - 4	aged 5 - 9	aged 10 - 15	aged 16 - 17

% of CiC accommodated during the month (**who remained accommodated**) and who had their **IHA within 20 working days** (Monthly trend)



Short Term / Long Term Placement Stability of Children in Care as at **31 December 2022**



Source: Data extracted from Mosaic following migration. Icon(s) made by Freepik at www.flaticon.com.

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Agenda Item 3

Report To:	The Department of Education recommend this report is presented to the following: • Warwickshire County Council Corporate Board • Corporate Parenting Panel • Safeguarding Partnership Executive Board • Integrated Care Board (ICB) A copy of the report will be provided to the DfE Regional Lead
Report Title:	Warwickshire Response to the National Review – Children with disabilities and complex health needs placed in residential settings
Report Author:	John Coleman, Assistant Director Children & Families In consultation with: • Nigel Minns, Strategic Director and Director of Children's Services. • Calvin Smith, Service Manager, Children's Safeguarding & Support • Becky Thompson, Service Manager, 0-25 Disabilities Service • Sharon Shaw, Service Manager, Corporate Parenting • Jo Davies, Principal Social Worker (leads LADO team) • Olivia Cooper, Service Manager, Quality Assurance, Commissioning Support Unit • Cornelia, Heaney, Operations Manager with responsibility for the LADO.
Date:	13th December 2022

Decisions Required		**Endorse Recommendations**		**For Information**	**X**

No.	Contents:
1.	Recommendations
2.	Purpose of Report & Background
3.	Analysis
4.	Conclusions
5.	Appendix

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1.	The Recommendations of this report for Corporate Board to consider are:
1	Note the response, actions taken and findings to the National Review – Children with disabilities and complex health needs placed in residential settings

2. Purpose of Report

2.1 On 23rd August 2022 all Directors of Children's Services received a letter from Annie Hudson, Chair of the Child Safeguarding Practice Review Panel requesting specific action was taken within three months and reported upon within one month after completion (by 23rd December 2022).

2.2 The National Child Safeguarding Practice Review Panel ("The Panel") is currently undertaking a national review into safeguarding children with disabilities and complex health needs in residential settings. The Review is considering the experiences of children placed in three specialist independent residential settings located in the Doncaster area (Fullerton House, Wilsic Hall and Wheatley House) and operated by the Hesley Group. The Review is being led by Dr Susan Tranter, supported by Dame Christine Lenehan, Director of the Council for Disabled Children (CDC), for the National Children's Bureau (NCB).

2.3 The Review and request to DCS's focussed on 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. It is estimated that there are around 1,700 children nationally who would meet these criteria. This review is considering allegations of widespread abuse (and which are subject to a live criminal and associated investigation). Phase One has considered the experiences of children placed in the Hesley provision in Doncaster. This includes developing an understanding of how children came to be placed in these settings, what happened to them and what factors and issues may have contributed to their experiences of abuse and neglect. Phase Two will consider the broader safeguarding needs of this group of children and young people and will make recommendations to improve safeguarding policy and practice. Work on Phase Two will commence in late autumn and conclude by March 2023.

2.4 Annie Hudson Chair of the Child Safeguarding Practice Review Panel reported that she recently wrote to the Secretary of State for Education, with an update on the emergent findings from Phase One of the Review and drawing attention to three urgent actions that the Panel believes to be necessary. Responsibility for two of these urgent actions lies with Directors of Children's Services (DCSs) and the third action lies with OFSTED.

2.5 Directors of Children's Services were requested to complete a number of actions (see below) as they believed that these actions are essential to provide

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assurance that other children living in similar types of residential placements are safe and are receiving the most appropriate and high-quality care.

2.6 The request was also very clear that following completion of the actions, a report should be shared with key responsible individuals and partnership board including the Corporate Parenting Panel, Safeguarding Partnership Executive Board and Integrated Care Board (ICB). A copy of this report is also required to be sent to the West Midlands Regional Lead from the Department of Education, which was sent on 13th December 2022.

3. Analysis

3.1 Urgent action one

In relation to this group of children (as defined in the appendix), all Directors of Children's Services should ensure:

(A) Directors of Children's Services 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. Covering the list of relevant points and questions to support these reviews, (see appendix document).

(B) 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.

(C) DCSs are 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.

(D) DCSs are also asked to send a copy of this overview report on the Quality and Safety Reviews to the relevant DfE regional improvement support lead (RISL) (see Appendix B for a list). The Panel's national 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.

3.2 In response to Action One the allocated Social Worker for every child was requested to complete an additional visit and a Quality and Safety Review. A member of the Quality Team within the Commissioning Support Unit also visited each child and both the care and education provision. A template with each of the questions and issues requested to be covered was formulated. A form was completed by the Social Worker and Quality Assurance Officer, they were all authorised a Team Manager. The information in this report has been collated

from the information collated, which was recorded on each child's file.

3.3 In total, Warwickshire identified there were 29 children who meet the criteria for review. The Social Worker and Quality Assurance Officer visited children within their residential home, with a separate visit to the school, if necessary, where it was not on the same site. Reviews were completed face to face with the child in order to keep the child central to the review process and hear the child's voice regarding their day-to-day experience of the setting/s. Feedback regarding support received from the setting/s were requested from family member's and the key professionals involved. The care delivered and the quality of care was reviewed, considering intelligence known of the service, staff ratios and training. The visiting social workers worked alongside staff from the Quality & Assurance Team, to agree the final RAG rating.

3.3 The key findings were:

- Out of the 29 reviews completed, 27 young people were receiving services from residential settings RAG rated as green with no significant concerns by the allocated Social Worker and Quality Assurance Officer.

- In two cases concerns were raised, these mostly related to recruitment, staffing levels and use of agency staff by the residential setting. The review confirmed that the provider had a mitigating plan and improvements were being realised. Whilst the RAG rating was amber for the setting, the review identified no specific concerns relating to the young person and concluded that needs were being met, also one young person was due to move imminently. In one of these cases, the young person advised that they at times struggled to cope with staff changes.

- In one case the Quality Assurance Officer graded the home Amber because the unit had an Inadequate grading from OFSTED. In fact, OFSTED closed the unit shortly after our assessment process. Any concerns raised about units' processes were relatively minor and appeared to be being addressed. The Q&A Team saw progress being made and were surprised at OFSTED's decision to close the unit.

- The children's views were almost universally positive, with no significant complaint or concern being raised by the young people. In fact, most were really positive. One young person would have preferred to go home but accepted that was not possible yet and another wanted to move to their new step-down foster placement but was still positive about the unit. In 4 of the 29 young people in RAG rated green residential settings wished to move to different settings. Three wished to move back with family and there was a plan to facilitate this outcome for one of the young people. Another young person wished to move to a smaller setting with a family feel which a plan was in place to facilitate. In both reviews, the residential setting was assessed as being able to meet the young

person's needs but that the young person wished to move to meet their identified outcomes.

- The parents of the children/young people had nothing negative to say about the units nor the experience of their children within the units. In fact, it was generally the case that they were very positive about the progress the children had made while in the setting, both socially and educationally. We did not manage to obtain the views of one parent, but they have a pattern of non-engagement and non-attendance at reviews. For this young person we did speak to their aunt, who has regular family time with the young person and attends his reviews at his request. The aunt was positive about the unit. The units seemed to be universally helpful in supporting family time, with parents and siblings.

- The views of other professionals (in the main SENDAR staff and IRO's) was generally positive about the units. All professional opinion recorded positive progress for the children/young people in placement. This included education progress with SENDAR satisfied the education provision met need. They raised no significant concern. There were a couple of issues e.g. a missed Personal Education Plan for one young person, in one term only. There was also varying issues about the ability to get the local health service or mental health service to meet the child's needs. This was more of an issue related to the difficulties in children placed out of county and navigating individual services in the specific locality. No professionals raised concerns about the actions or support from providers to try and resolve these issues, indeed many felt they had been supported to navigate local health and mental health services to ensure children's needs were met.

3.4 In summary, with the exception of the two young person in an amber rated residential setting, one due to recruitment issues in the unit and the other due to the setting being graded inadequate by Ofsted, all the young people allocated are living in safe and their needs were being met. No child/young person or professional raised a general concern about any unit with all the children seen to be having their needs met and most making significant progress. The completed reviews highlight that young people are supported by the residential provider to maintain quality family time, family appear to have good relationship and communication with the provider. Young people are happy, well cared for and are thriving.

3.5 <u>Urgent Action Two</u>

In relation to this group of children (as defined above), all Directors of Children's Services should ensure:

I. That the host authority LADO for each individual establishment reviews all

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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.

II. 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.

3.6 In response to Action Two, point I. Information provided by WCC Children's Commissioning team identified three establishments meeting these criteria. An audit of all the referrals (investigations requiring LADO oversight) and contacts (requests for LADO advice) at these establishments during the previous three years 2019-2022 was undertaken by members of the Practice Improvement and Quality and Impact team. Where the auditors identified any areas for improvement, these were moderated by an experienced LADO manager to identify outstanding tasks or learning for the review.

3.7 One closed referral was found where there was doubt about whether all elements of the referral had been fully investigated and acted on. An immediate check was made which established that the employer had conducted all investigations as required, and that the result of these was that the employee was dismissed and referred to the Disclosure and Barring Agency (DBS) as required. There were no open cases of staff in any of these establishments.

3.8 In response to Action Two, point II. There are no outstanding enquiries being carried out regarding staff employed in these homes. The auditors endorsed the initial threshold decisions made by a LADO in all but one case (as described above), the adequacy of their oversight of investigations and their recording of a clear determination and rationale.

3.9 There were a very small number of cases where the auditor queried the sufficiency of what was recorded on the case file (6 files) however moderation of these found that in one case the auditor did not have permission to view all relevant materials, and these were on the file, and in others the auditor had misunderstood some element of the LADO role.

3.10 This left three files where there were gaps identified. One of these did require follow up and is highlighted in the action summary above. Another identified that the usual best practice action of recording a DBS application number was missing and the third that the investigation had not included seeking a child's views when this might have been expected. However overall efforts to establish individual children's views was a strength of the files reviewed, with LADOs seeking out social workers all over the country to triangulate what they were hearing from the children's home.

3.11 These findings mean that we can have a high level of confidence in the determinations (outcomes of referrals) as recorded in the Mosaic report.

3.12 <u>Witherslack Group.</u>

There were 45 referrals/contacts received by the LADO service in the time period being reviewed and it is noteworthy that 3 people were referred (or

consulted about) 5 times. The files showed LADO advice to the employer acknowledging repeat referrals and asking them to consider whether there were other training or development needs for staff who were the subject of repeated unsubstantiated/false allegations.

During 2019 and the first part of 2020, there was a high rate of referrals from managers revealing that they were not able to manage challenges in the home authoritatively and appeared to be looking to LADO advice too readily. As a result of spotting this pattern, the LADO had provided information to Ofsted who undertook an inspection of the two premises in Warwickshire and suspended their registration for a period on 31st July 2020. An internal review of the County Council's response to the failures in the organisation found issues with internal information sharing and resulted in the development of a process to facilitate communication of provider information between the LADO service, Children's commissioning and the Quality team.

Over the review period, 8 contacts were recorded for advice only. A further 3 were found not to meet LADO criteria after investigation.

5 allegations were substantiated, including 2 for physical abuse of a child in the home and two for neglect of children in the home. The fifth was emotional abuse from a shift leader.

5 allegations were unsubstantiated. (Insufficient evidence to show on the balance of probability that the allegation was true, but also insufficient to say it was untrue.) 4 of these allegations were for physical abuse, two in the context of an authorised restraint.

12 allegations were found to be false, all arising out of a situation where restraint or physical intervention was used with the young person. This means that it was found on the balance of probability that the member of staff concerned did not harm the child, but the number of these investigations caused the LADOs to be concerned about the culture of the organisation and contributed to the decision to refer to Ofsted.

A further 6 allegations were found to be unfounded or malicious. An unfounded allegation is one made with no proper basis and a malicious allegation is made with an intent to deceive.

3.13 Young Foundations.

There were 21 contacts received in the relevant time period, 6 (out of 15) people were referred twice in the period under review and no members of staff referred more than twice. This is a more expected referral pattern.

6 were recorded as contacts for advice only. Following investigation, 9 further referrals were found not to meet LADO criteria.

No allegations were substantiated. 3 were found to be unsubstantiated. One of these referrals was for assault, another for alleged indecent behaviour and the third for unboundaried behaviour suggesting the person was unsuitable to work with children.

6 were found to be false, unfounded or malicious, i.e. there was sufficient evidence to find on the balance of probability the allegations did not happen.

3.14 Action for Children

No referrals were received relating to staff in the Action for Children home during the period under review. We considered whether this could indicate that the home was under-referring.

This home provides short respite stays for children with disabilities. The manager of this home has proactively invited the LADOs in to give in-person training several times over the last few years. The LADOs have found the team receptive to their input, and have noted that the management team is stable, and all are secure in their roles and responsibilities. Children stay for one or two nights, and staff and ratios are high. Any children who had a poor experience in their stay would be soon in the care of their families again and able to disclose, or show through their behaviour, that they were unhappy.

The staff team have made appropriate referrals about other professionals involved in transporting children to and from respite, indicating that they understand referral criteria.

We are satisfied that the managers would refer their staff if required, and that the absence of referrals reflects a good standard of care and management support in the home.

3.14 Below is a table detailing LADO referrals and is correct and completed on 9th November 2022.

	Witherslack Group	Young Foundations	Action for Children	TOTAL:
CONTACTS	45	21	0	66
PEOPLE	29	15	0	44
1 contact	20	8	0	
2 contacts	3	6	0	
3 contacts	1	0	0	
4 contacts	0	0	0	
5 contacts	3	0	0	
6 contacts	0	0	0	

4. Conclusions

4.1 In conclusion, the actions requested by the Chair of the Child Safeguarding Practice Review Panel have been completed. The reviews highlighted no significant concerns or actions as described above, children were found to be happy, well cared for and are thriving.

4.2 The review process did highlight capacity issues in the Children's Quality Team. However, funding has been located to extend roles and capacity until 31.03.2024 and the Commissioning Support Service will be seeking a

permanent solution to ensure continued permanent capacity for Quality Officers to regularly undertake quality reviews with the allocated social worker.

5. Appendix

5.1 Letter and terms of reference from the National Panel are attached for information.

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Child Safeguarding
Practice Review Panel

23 August 2022

Dear Director of Children's Services

National Review – Children with disabilities and complex health needs placed in residential settings

Urgent action required

As you will be aware, the Child Safeguarding Practice Review Panel ("The Panel") is currently undertaking a national review into safeguarding children with disabilities and complex health needs in residential settings. The published Terms of Reference for the Review are here.

The Review is considering the experiences of children placed in three specialist independent residential settings located in the Doncaster area (Fullerton House, Wilsic Hall and Wheatley House) and operated by the Hesley Group. The Review is being led by Dr Susan Tranter, supported by Dame Christine Lenehan, Director of the Council for Disabled Children (CDC), for the National Children's Bureau (NCB). The Review is being completed in two phases. We plan to publish our Phase One report in the autumn.

For the sake of clarity, the Review and this letter is focussed on 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. It is estimated that there are around 1,700 children nationally who would meet these criteria. This review is considering allegations of widespread abuse (and which are subject to a live criminal and associated investigation). We expect that families of children living in similar settings may rightly be concerned about the safety and welfare of their children if and when they learn about what has happened in the Hesley provision in Doncaster.

Phase One has considered the experiences of children placed in the Hesley provision in Doncaster. This includes developing an understanding of how children came to be placed in these settings, what happened to them and what factors and issues may have contributed to their experiences of abuse and neglect. Phase Two will consider the broader safeguarding needs of this group of children and young people and will make recommendations to

improve safeguarding policy and practice. Work on Phase Two will commence in late autumn and conclude by March 2023.

I have recently written to the Secretary of State for Education, providing him with an update on the emergent findings from Phase One of the Review and drawing his attention to three urgent actions that the Panel believes to be necessary. Responsibility for two of these urgent actions lies with Directors of Children's Services (DCSs) and the third action lies with OFSTED. This letter is therefore to advise you of the two actions that fall to DCSs and to ask for your cooperation in initiating them in the suggested timescale. This letter also provides you, for information, with a brief explanation of that third action.

Children in care with disabilities and complex health needs in specialist residential settings should be living in safe and good quality placements. However, the serious abuse and neglect revealed by this Review and the related criminal and associated investigation means that there is a need for additional assurance about the safety and well-being of children living in similar types of placements.

The Panel hope that you will work in collaboration with your local safeguarding partners, Integrated Care Systems (ICS) children's leads, NHSE regional leads or regional teams, the Department for Education (DfE) and the Panel to undertake the two relevant actions detailed below. We believe that these actions are essential to provide assurance that other children living in similar types of residential placements are safe and are receiving the most appropriate and high-quality care.

Urgent Action One

I. Directors of Children's Services 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. Please see Appendix A for a list of relevant points and questions to support these Reviews. These reviews can be incorporated into routine care review planning processes but should ensure that all the key points and questions identified in Appendix A are properly addressed. You will wish to ensure that the Reviews are carried out by and involve appropriate professionals. Reviews should apply to all children in such settings, that is those who are resident for part of the year as well as those who are resident for all of the year.
II. 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.
III. DCSs are 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.

IV. DCSs are also asked to send a copy of this overview report on the Quality and Safety Reviews to the relevant DfE regional improvement support lead (RISL) (see Appendix B for a list). The Panel's national 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 Two

In relation to this group of children (as defined above), all Directors of Children's Services should ensure:

I. 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.

II. 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.

You are asked to confirm that urgent action two has been taken through the overview report that you will be providing to the DfE Regional Improvement Support Lead on Action One above. DfE in turn will confirm to the Panel that the Reviews have taken place.

Timescales for Actions One and Two

The two actions above should be completed within **three months** from the date of this letter. We would then expect that the overview reports are completed and shared with local corporate parenting boards, safeguarding partners and your Regional Improvement Support Lead (RISL) for your area (see list at Appendix B) within a month of the completion of the actions.

Urgent Action Three

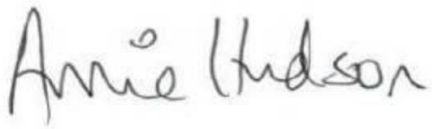
You will also want to note that Ofsted are being asked to conduct an immediate analysis of their evidence around workforce sufficiency focusing on its suitability, training, and support. More information will follow in the Panel's Phase One report due to be published in the autumn.

I am copying this letter to the Chairs of the Integrated Care Boards (ICBs) and the Business Manager for each area's Safeguarding Partners. I would request that the Business Manager forwards a copy of this letter to the relevant statutory partners. I would also request that you forward a copy of this letter to your local authority's Chief Executive for their information.

If you have any queries on any of the above, please email the relevant RISL for your area (as they have been fully briefed and can support you with any questions).

Thank you for your co-operation in this matter.

Yours sincerely,



Annie Hudson
Chair of the Child Safeguarding Practice Review Panel

Appendix A

The Quality and Safety Reviews will ensure that:

- Children's communication plans are in place, updated and there is evidence of how they are used.
- Children have positive behaviour plans in place, and staff are trained and supported to use them.
- Children have accurate, up to date medication records and medications are securely stored and that there is appropriate use of medication (e.g., consider use of Pro Re Nata (PRN) medication).
- Children's physical and mental health needs are met and understood.
- Children are attending school and have clear progress targets.
- Children are supported to have the maximum contact with those who care about them, including parents/carers and siblings.

Reviewers will need to;

Ensure they hear the voice of the child and know what their day-to-day experience of care is like by:

- Using the methodology of the communication plan to obtain the maximum opportunity of hearing directly about the child's experience, (this must include seeing the child face to face).
- Talking directly to families about the child and about how they experience the child's placement.
- Talking to key professionals in the child's life and ask about their experience of placement.
- Ensuring the child is seen in both home and school.

Reviewers will need to ensure that the child is receiving a safe, quality placement by:

- Checking if any safeguarding issues have been raised and, if so, that these have been followed up appropriately. This will include looking at all notifications in the last 12 months and all physical intervention records and if necessary, ensure appropriate follow up is in place.

- Assuring themselves that liberty protection safeguards are in place where needed.

- Looking at staffing records to ensure children have the ratios agreed by the contract.

- Assuring themselves that all outstanding actions from Annual Reviews have been completed.

APPENDIX B

Names and contact details for the Regional Improvement Support Lead

Region	RISL	Contact
London	Céline Dignan Shannen Grant	Celine.dignan@education.gov.uk Shannen.grant@education.gov.uk
North West	Ivan West	Ivan.west@education.gov.uk
East of England	Jo Page	Jo.page@education.gov.uk
South East	David Myers	David.myers@education.gov.uk
South West	Genevieve Cox	Genevieve.cox@education.gov.uk
North East	Sarah King	Sarah.king@education.gov.uk
Yorkshire and the Humber	Kate Gillan	Kate.gillan@education.gov.uk
East Midlands	Stewart Bembridge	Stewart.bembridge@education.gov.uk
West Midlands	Rachel Newton	Rachel.newton@education.gov.uk

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National review into safeguarding children with disabilities and complex health needs in residential settings

Local Authority FAQs

Introduction

The independent Child Safeguarding Practice Review Panel (the Panel) has concluded that a national child safeguarding practice review should be undertaken into the allegations of abuse at Fullerton House, Wheatley House and Wilsic Hall independent specialist residential facilities for disabled children.

Allegations of harm to children living in these three privately run residential facilities, operated by the Hesley Group and located in Doncaster, came to light in March 2021. The Panel received a rapid review on 10 September 2021, where Doncaster Safeguarding Children Partnership requested the Panel undertake a national review.

Dame Christine Lenehan DBE, Director of the Council for Disabled Children at the National Children's Bureau, is conducting the review on behalf of the Panel.

The Child Safeguarding Practice Review Panel lead for this review is Dr Susan Tranter.

FAQs

About the review

Why has the Panel decided to undertake a national review?
The Panel has initiated this national review because of concerns and allegations that children with disabilities and complex health needs have suffered harm in three independent residential facilities in Doncaster. The Doncaster Safeguarding Children Partnership requested that the Panel undertake a national review because of the wider, national implications posed by the allegations.

What is the outline of the review?
This review will look in detail at what happened to children placed in the three independent residential facilities in the Doncaster area. It will ask some important questions about how children with disabilities and complex health needs are safeguarded and how agencies worked to ensure that their rights and needs were met and voices heard. Most importantly, it will seek to identify ways in which practice and policy might need to change to protect children with disabilities and complex health needs better in the future.

How will the review be structured?
The review will be conducted in two phases:

1. The first phase will focus on understanding the children affected. These children have all now been moved to safe placements elsewhere, but the review team needs to establish how they came to be placed at the facilities being investigated, and how they were supported while in residence. The review will capture a range of information on all of the children and their individual needs. The first phase of the review will be completed by the summer of 2022.

2. The second phase will seek to understand whether what happened to these children is indicative and typical of practice more generally, and, if this is the case, set out what should be in place to prevent children with disabilities and complex health needs from harm. The second phase of the review will be completed by 31st March 2023.

This two-phased approach will help ensure that the learning about safeguarding practice is shared with the system as quickly as possible.

Why has Dame Christine Lenehan DBE been appointed as the lead reviewer?
The Panel appointed Dame Christine Lenehan DBE as the lead reviewer due to her wealth of expertise in this area.

As Director of the Council for Disabled Children (part of the National Children's Bureau), Christine works tirelessly to bring about a fully inclusive society where all disabled children and young people can achieve their aspirations and do not feel excluded. Christine has overall leadership and responsibility for the Council for Disabled Children and all of its activities.

In 2016, Christine was asked by the Minister for Care and Support to look at the challenges in the health system for children with complex needs, learning disability and autism. The report 'These are our children' was published in 2017. Christine was then asked to review the needs of children in specialist residential schools and colleges and her report 'Good intentions, good enough?' was published in late 2017.

What measures are in place to ensure sensitive information about those affected is kept confidential?
The experiences of children and young people are at the heart of this review. Information and case studies about individual children and young people in the review's report will be anonymised to protect the identity of the children in question and to preserve the integrity of the investigation.

All data in regards to the review is being kept securely and a data sharing agreement and media response protocol have been established to ensure effective coordination between the Panel, Doncaster Council, Ofsted, South Yorkshire Police and the National Children's Bureau.

How will the review align with the ongoing criminal investigation?
The review is focussed on safeguarding practice and the safeguarding system. The Panel is in regular communication with the senior investigating officer at South Yorkshire Police and senior officers at Doncaster Council to preserve the integrity of the criminal investigation.

How can I find out more about the review?
The Terms of Reference for the review, and correspondence between the Chair of the Child Safeguarding Practice Review Panel and Government Ministers, can be found on the Panel's website.

How will stakeholders be involved in the review?
The review will include a stakeholder focus group including NHS leaders, academic researchers, people with experience of parenting a child with disabilities/complex needs, and key stakeholder groups. The members of the expert focus group will be announced as soon as they are confirmed.

How will the review ensure the voices of children, young people and families are represented in the review?
As the review progresses, we will engage with a range of organisations and individuals with relevant experience of involving children and young people with disabilities in their work. The review will draw on this experience to create 'experts by experience' focus group to reflect the views and experiences of children and young people with disabilities, and parents and carers.

How are we seeking the views and ideas of the those that work with children and young people with disabilities?

The review will consider evidence from a wide range of experts, organisations and practitioners working to safeguard children and young people with disabilities, as well as private companies and local government leaders working in this area**.**

How should local authorities respond to any media inquiries and any requests for information
All media inquiries should be forwarded to the Child Safeguarding Practice Panel. Similarly, if a Local Authority requires any information linked to the review, they should contact the Panel via Mailbox.NationalReviewPanel@education.gov.uk.

How will the local authorities who had children placed at these schools be expected to take part in the review?
Relevant local authorities may be asked to contribute to the review via bilateral conversations or roundtables, and may be asked to provide data and information to the reviewers. The Panel will make direct contact with Local Authorities and relevant bodies where such requests are to be made. The review is seeking to produce its findings and recommendations, in the first phase by the summer of 2022, and therefore it is vital that Local Authorities and relevant bodies respond quickly to any requests made.

How should local authorities communicate about the review with their staff, particularly in regards to the social workers and other agencies involved with individual children?
The Panel will work with the relevant safeguarding partners to help inform their workforces about the review in a coordinated and clear way. The Panel is keen to ensure that any concerns are addressed early in the process.

How should local authorities communicate about the review with families who may be directly affected or may be concerned about children placed at other residential facilities?
Following the announcement of the review, parents may want to confirm the local arrangements for how their child is supported and their safety ensured with their social worker and/or local authority. A factsheet for parents has been included with this document. The Panel is happy to respond to local authorities to help address any concerns from parents.

Dame Christine Lenehan may wish to drill down in more detail into a number of cases and this may involve speaking to parents. The planning and communication around any interaction with parents will be crucial and local areas will be part of the process.

How will the link with education be picked up during the review?
Whilst the review will focus on child safeguarding practice, Dame Christine Lenehan is mindful to look at all aspects of the children and young people's experience, including the education element. Child Safeguarding Practice Reviews are multi-agency in nature and we will of course look at the whole care offered to the children and the interplay between the registration of being a registered school and a registered social care provider.

Please direct any queries, questions or concerns to Mailbox.NationalReviewPanel@education.gov.uk

Parents' concerns
What has been done to protect the children in these residential facilities?
Children in the residential facilities being investigated were moved to alternative provision following Ofsted's suspension of their registration when allegations of harm came to light in 2021. The safety and wellbeing of all the children and young adults in these settings has been at the heart of all decisions made. The families of the children are receiving ongoing

support as the investigation continues.

How can we know this isn't happening or has happened to other children in other areas?
Phase two of the review's work will seek to understand how widespread the risk to disabled children in similar residential settings is, and whether failings evident in the facilities being investigated are likely to be duplicated elsewhere.

How can the parents of children living in similar residential settings be sure their child is safe and that the setting is following the correct procedures?
All children placed away from home should have links to their home authority, and social workers and other professionals should be working with families to make sure that children are safe and well cared for in their placement. Ofsted regularly inspects schools and residential settings for children and young people with special educational needs and disabilities.

What should parents concerned about the safety of a disabled child in a residential setting do?
Parents may want to confirm the local arrangements for how their child is supported and their safety ensured with their social worker and/or local authority.

How are children who were placed in the three facilities and their parents/carers involved in the review?
Dame Christine Lenehan may wish to drill down in more detail into a number of cases and this may involve speaking to parents and children. The planning and communication around any interaction with parents will be crucial and local areas will be part of the process.

Is the review providing advocacy for the children affected?
The home Local Authority continues to have responsibility to ensure individual needs of children are met including advocacy.

How are children being helped to recover from any harm they have suffered?
As children were reassessed and moved from the residential facilities, consideration was given to any harm they may have experienced. Parents may want to confirm any specific support required with their social worker and/or local authority.

Where can families get support and advice?

- **The National Autistic Society** prides an extensive range of support, guidance and advice for families on its website.
- **The Challenging Behaviour Foundation** also provides detailed guidance on its website and a dedicated Family Support Helpline on 0300 666 0126.
- **NSPCC's Childline** is available 24/7 on 0800 1111.

Corporate Parenting Panel
Work Programme 2023

Updated 10 January 2023

Item	Report detail	Date of Meeting
Update from CICC and Care Leaver Forum	Receive an update from children and young people from the CICC and Care Leaver Forum.	* Standing items for every meeting
Performance Data	Report which includes key data regarding CLA & Care Leavers	
Development of Work Programme for 2023 and Forward Plan information	To consider proposed work programme & future areas of work for the panel; including information from the forward plan with items relevant to the remit of the panel	
Report from the Virtual School Head	• **Spring Term** (March/April) - annual report • **Summer Term** (July/August) - school stability, exclusions, attendance, PEP completion rates for the academic year, Post 16 overview • **Autumn term** (November) - data forecast for the academic year, Post 16 EET destinations	**Quarterly Report**

Report detail	Date of Meeting
• To consider the need and mental health timescales for care leavers and CLA receiving a CAMHS/RISE service and a report into the process for mental health assessments (Zoe Mayhew)	***To be rescheduled***
• Warwickshire Response to the National Review Children with Disabilities and Complex Needs • Outline for CPP Roadshows – verbal update	16th January 2023
• Governance for Child in Care and HELAC Feedback – Angela Richardson • Placement Stability for Children in Care – Sharon Shaw • The Vanguard Project – George Shipman	27th March 2023
2023/2024	
	19th June 2023
	18th September 2023
	13th November 2023
	15th January 2024
	25th March 2024

Actions from the previous meetings/Additions to the work programme

- A focus on short term placements and stability of placements.
- County Line – a police representative will be asked to attend
- Child Exploitation – suggest that this is a one item only agenda
- Partnership working with District and Borough colleagues - A Charter with shared objectives will be presented to the panel after April 2022
- Review into the turnover of Social Workers to identify any trends (John Coleman).
- Invitation to be sent to a representative of the Police to join a discussions in relation to missing children (Sharon Shaw).

Information circulated to Members outside of meetings - *none currently*

Items included on the Forward Plan relevant to the remit of the Panel:

The remit of the panel is to secure elected member and cross-organisation support and commitment for delivering improvement services and better outcomes for looked after children, young people and care leavers: *(updated 10 January 2023)*

Decision	Description	Date due	Decision Maker
Education Attainment Working Group Report	Overview of the findings of the Education Attainment Task and Finish Group	7 February 2023	Council

Future Meetings - 2022/23

- 16th January 2023 at 10am
- 27th March 2023 at 10am

Dates for 2023/24

- 19th June 2023 at 10am
- 18th September 2023 at 10am
- 13th November 2023 at 10am
- 15th January 2024 at 10am
- 25th March 2024 at 10am

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