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
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Date:	13th December 2022

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

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1.	Recommendations
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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

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

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 <u>Young Foundations.</u>

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.