Keeping safeguarding in view- reflecting upon the interim Hesley findings.

Chris Freestone/John Woodhouse . January 2023

Context

- On 26.10.22 Ofsted published a press release in respect of phase 1 of the Panel findings re. three Hesley Group RSS, with Children's Homes in the NW of England.

- This is far from an "easy or comfortable "read– it is a key document for us to realise that prolonged bad , abusive practice does still go on…..
- https://www.gov.uk/government/publications/safeguarding-children-with-disabilities-in-residential-settings
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Context :

- The Child Safeguarding Review Panel was asked to undertake a national review of the abuse of disabled young people in a school with attached children's homes at the Hesley group in Yorks.
- They have completed Phase 1 of their investigation with a very damning analysis of systemic failings for hugely vulnerable young people.
- We will reflect upon key issues with the challenge to review our own structures ,systems , practice and culture in the light of this phase 1 report
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Context continued

- It is profoundly shocking that, in the twenty first century, so many children who were in ‘plain sight’ of many public agencies could be so systematically harmed by their care givers. The Independent Inquiry into Child Sexual Abuse (IICSA)1 has highlighted profound historical deficiencies in the safety and quality of residential care for children. This review evidences how some children continue to be failed by a system that should be caring for and protecting them.
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Key issues and themes

1.Practitioners, particularly those working in residential settings, do not have access consistently to the support and quality of leadership they need.

2.Evidence of the abuse and harm experienced by the children included: physical abuse and violence, neglect, emotional abuse, sexual harm, and medical needs not being met. There was also evidence that medication was misused and maladministered.

3.Staff did not respond effectively to allegations or disclosures made by children against staff members.

4.Incidents that indicated safeguarding risks were too often not recognised as such.

5. There was an over-use of restraints and disproportionate use of temporary confinement.

Key issues and themes

4.Children who had profound difficulties with receptive and expressive communication received little support to participate in review meetings or report the abuse they had experienced.

5. Inadequate and insufficient consideration was given to the education, health and care needs of the child and the impact that their placement would have on the other children.

6. Leadership and management in the three settings were inadequate and failed to meet statutory requirements, resulting in a culture of poor practice and misconduct by care staff.

Key issues and themes

7. Over 3 years , staff turnover at Hesley's children's residential settings in Doncaster was 38.6%.

8. Inaccurate and inconsistent record keeping and statutory reporting by the settings meant that OFSTED and the placing local authorities often had a false picture of the care, safety and progress of the children

9. Children and young adults in the settings were not provided with the appropriate ratios of staff and the level of supervision to meet their needs.

10. Staff received limited induction, and some did not have sufficient knowledge or training to recognise the signs that children were at risk and how to respond.

Key issues and themes

11.Local authorities and partner agencies placing children at the settings put great reliance on the reports provided by the settings, and did not sufficiently challenge them. There was a lack of triangulation with other independent sources of information about the children.

12. There were major failings in operation of the LADO function, resulting in allegations about the conduct of staff in the residential settings not being investigated to a satisfactory standard… there was a lack of formal liaison arrangements between the LADO function in local authorities where residential settings are located and their counterparts in placing local authorities to alert them about enquiries into staff conduct

Missed indicators

A rise-

1. in physical interventions
2. In incidents of medical maladministration,
3. allegations and complaints

- of particular concern was the response to non-verbal children who were displaying behaviours, signs and symptoms indicative of child abuse.

4. There was a lack of recognition that behaviour was itself a means of communication, and that behaviour that challenges may signal a need for support.

5. Incidents that indicated safeguarding risk were too often characterised as self-injurious behaviour that was deemed to be part of the child's disability.

In these circumstances, there was an over-use of restraints and disproportionate use of temporary confinement.

In some cases, staff at Hesley's children's residential settings in Doncaster had not been trained in the restraint techniques they were using, or were using them inappropriately.

Missed indicators

6. poor monitoring – missed patterns , themes and trends

7. poor oversight re. policy implementation , understanding and implementation of care plans

8. records kept and “not shared “ with Ofsted or any LA.

9. little or no external review- closed shop culture established. LAs took the reports from the schools at face value

10. pattern of not being able to see children individually or alone

11. LADOs passing too many “low level” concerns back to the provider for investigation

First set of internal Ofsted changes

- *the dates for the inspections of residential special schools and children's homes should be aligned, so that the provisions are inspected at the same time, wherever possible*
- *the last children's home report should be included in the pre-inspection information for the school inspection*
- *school inspectors should be briefed on safeguarding concerns, and information about complaints should be made available from the regulatory inspection manager*
- *inspection training should include training about 'closed cultures' in special education needs and disabilities settings, and the implications of this for the inspection*
- *inspectors conducting inspections in provisions where children and young adults may be non-verbal will have the requisite knowledge, skills and experience*
- (This last huge and welcome)

challenge

- Culture of the home - does it exist on paper or in reality ? How do you know ?
- Systemic failings- how quickly can they set in ? Any cause for concern ?
- Detecting and acting upon indications of a closed culture
- Four key factors in place – professional curiosity/vigilance , forensic analysis , none assumptive , non biased? If not in place , why not?
- Records ….
- Communication
- Young people…..
- External agencies

Small group / group discussion

- Key issues are clear within this shocking review , the final findings of which will add to the huge amount of planned feedback , response from Government during the next few months to a year.
- Thinking about the settings you visit – what do you have in place which satisfies YOU that these issues would not /are not occurring.
- Discussion / feedback

Any queries or questions ?

- Looking forward to seeing you next time.
  Chris