“We must ensure this never happens again”.

An open letter to whom it may concern, which is all of us, in any way at all involved with Children Looked After

This is no time for finger pointing, only learning.

This open letter is a call to action.

Why is this letter being written? Why is it necessary?

- 28 children’s homes have recently been closed, this is not because of concerns related to safeguarding, it has been said that the homes were successful, well-run, happy homes.
- Children have been made homeless. Some had lived in their homes for years and had deeply caring relationships with their staff. They had schools and therapeutic services assisting them.
- Tens, if not over a hundred, staff members have lost their jobs.
- Tens, if not hundreds, of families of low paid workers now have no income.

Ofsted evaluate all moves into and from homes. The measure is that it should be better (more suitable to their needs). Stability supports continuity of care and the experience of a secure emotional base. Surrounded by resilience a child absorbs it and gains confidence in their identity and ability to explore their world. How might they evaluate this change for all of the children involved?

Media reports tell us that:

- At least one child was distressed.
- At least one child refused to leave and had to be forcibly removed.
- At least one child went ‘missing’ from the new home.

The children had built relationships with the staff. They had schools. They were getting therapy. It was their home not just a home. **All this stopped**.

Imagine children living with 28 random families being told that they must leave, find new homes, new families. Would that have led to a public outcry? Most certainly.

‘I was given days to find myself a place to live’: autistic teenager on care home eviction | Social care | The Guardian

‘Heart-breaking’: private care homes accused of failing UK children due to closures | Social care | The Guardian

There is a troubling absence - there has been neither public concern nor outrage

Noone has said, “We must ensure this never happens again”.

Given the current conjuncture of existing factors we must take action to ensure it can never happen again.

Where is the clamour? Should there not be an enquiry?

Do we realise or recognise that this is the fourth time incidents like this have occurred?

Probably not, as there has been some time passed between events. Time enough for a whole cohort of people to have joined and others to have moved on from social care. Only a few of us remain to hold the continuity of knowledge and experience.

These closures are more extensive than any previously.

1. Local authorities closed their homes systemically in the 1980's and 1990's – less than 20% of homes are run by local authorities today. Once it was nearly 100%. Many local authorities no longer have expertise in operating children's homes.

2. Large Voluntary Organisations closed their homes in those and successive decades – now fewer homes are run by them. They too have less staff holding the expertise to run children's homes

3. These recent closures are more devastating than a previous provider, Sedgemoor, closing homes. Then, other private providers bought and kept homes open. A world shattered | Schools | The Guardian and Private equity accused of undercutting long-term home providers - Community Care

These closures come at a time when there is a widely acknowledged shortage of children's homes, if it were not the case the DfE would not be funding local authorities to open more, though currently it is too few and too slow.

There has been a worrying and dramatic increase in the numbers of children coming into care. This rise has been continuing since 2008 and there has been a year on year increase in numbers since then, rising to 82,170 in 2022. It has been suggested that the needs of this cohort are more complex and diverse than hitherto. Complex needs definition, children have 4, or more, co-occurring interacting high level needs.

- How do local authorities begin to look for places for this number of children in a provider base where vacancies are extremely restricted?
- They are already facing a multitude of referrals which will add to this number, the rise during 2021-2022 was 2%. How do providers make a judgement over offering the most appropriate placement?
- How do 28 x 12 staff find employment?
- How do 400+ staff and families make ends meet?

The Quality Standards, and Regulations, and the Regulator were meaningless.

None were contravened.

Employment law does not match child safeguarding.

Employment law was met.

There are no safeguarding reports known.

Only a few media reports followed, though ending profit is trending as a topic.

On checking Parliamentary proceedings, there is nothing in Hansard.

So not a single MP asked an Urgent Question? Nothing in all of Parliament? No inquiry yet announced by the Education Select Committee. Are there no concerns?

Nothing was heard from the Children's Commissioner – did the Commissioner act to freeze placements? It seems not. We need to know. Is she concerned?

Dozens of vulnerable children were disrupted yet nothing was said

28 homes, many children, staff and families were affected – yet nothing was said.

An honourable few in the media held the line. As ever, news moves on – as did all of these children – where to? It needs to be a matter of record. This is an important aspect of ensuring it never happens again. What was the matching possible?

The Children's Homes Association issued a media notice that described the decision to close as "unacceptable and falls woefully short of the standards expected from all providers in this vital sector" seeing "no reason why such drastic action would be necessary or justifiable for any responsible, properly run residential childcare organisation". Decision to close more than 25 children's homes unacceptable - The Children's Homes Association (the-cha.org.uk) The provider was not a CHA member. The statement continues addressing "unprecedented pressures" and "rising costs" and describing a "crisis in children's residential care" outlining factors of "record numbers of children in care with an alarming increase in high acuity cases; woefully underfunded local authorities; historically high and persistent inflation; and a severe recruitment and workforce crisis".

To protect children's interests the ADCS has called for exploration of a power in children's services like the local authority provider failure duty in adult social care under the Care Act 2014.

The lack of a legal mechanism for local authorities to step in and run homes has long been brought to attention by NCERCC. This seemingly simple solution is only to the symptom though, not the cause.

The LGA has saw the situation arising from a "lack of significant oversight in the children's home market (that) has meant the risks and impact of providers leaving the market, or no longer providing specialist services, are not properly understood. This is leaving parents and local authorities struggling to find the right homes for some of the most vulnerable children".

Both LGA and ADCS comment on the crisis of supply. The situation described could be rectified by local authorities opening homes and with direct specificity as to the needs and methods and staffing required.

What actions did others take? We need to know if:

- Any of the children were provided with a legal advocate?
- Unions advocating for staff, if any, also included children in their arguments?
- Were Children's Rights organisations connected to children? Was there campaigning? Providing advocates?

Did regulations and regulatory actions fail?

There is a case to be made of the situation being a systemic failure of regulation and regulatory activity. The situation was not covered by the regulations or regulatory activity, internal QA and, or Ofsted activities.

- *If Quality Standards were not being met it should be noted and reported by the monthly independent visitor (Regulation44: these are signed off by the Registered Manager and Responsible Individual)*
- *Regulation 45 reports should have noted and included in the Action Planning..*
- *Staffing should be a matter addressed in these reports e.g. excessive use of agency staff or overtime?*
- *Effects as result of shortfall of staff, impingements on positive relationships, care planning, protection of children.*
- *As these are read by Ofsted this would be a means of awareness raising for the regulator of staffing shortfall, and initiate follow up activity.*
- *Viability of financial arrangements is matter of registration but in this case other factors were given as reasons especially staffing. This should have been reported by Regulations 44 and 45, acted upon by provider, and have triggered inspections by Ofsted*
- *There is a case to be made of the situation being a systemic failure of regulation and regulatory activity. The situation was not covered by the regulations or regulatory activity, internal QA and Ofsted.*

Reading necessary to review the situation

Leadership and Management Standard – 10.4, 10.5, 10.6, 10.17

Regulation 13

Guide to the QS - 'sufficient staff' = enough suitably trained staff (including someone in a management role) on duty to meet the assessed needs of all children in the home- continuity of staffing so that children's attachments are not overly disrupted

See also Quality Standards regarding:

- **Positive relationships**
- **Protection of children**
- **Care planning**

Financial position - Regulation 47

Quality Standard 14. 11

Notifications

It is for the registered person to judge who else it is appropriate to notify depending on the individual circumstances of the incident relating to the protection, safeguarding or welfare of a child living in the home which the registered person considers to be serious.

See also:

Registration

Staffing is a crucial aspect of registration. But the responsibility to maintain staffing at a suitable level goes beyond the conclusion of the registration process as temporary shortfalls in staffing must be notified to Ofsted and an action plan for resolution must be provided.

Noted in R44 and R45 and inspection reports – prolonged shortfall is a matter of leadership and management and affects overall outcome of inspection.

(Also acted outside of Care Planning if IROs not informed?)

Commissioning – the extent of due diligence being exercised?

Social work liaison - how was this being met by provider and social workers?

Regulation 5

- ***'seek to involve' the placing authority that places a looked-after child in the home*** = means working primarily with their statutory social worker… strong working relationship
- **Relevant plans** = any placement plan; any care plan; any statement of special educational needs; any education, health and care plan; detention placement plan or similar

Such partnership working should always take place: before a child arrives; while the child lives in the home and where the child prepares to return home, move to another setting or leave care.

How was this all allowed to happen? Could it happen again? Will it happen again?

As it stands the answers are 'Because it could'; 'Yes' and 'Quite possibly'.

The only way that those answers can be changed is if enough people are willing to act to ensure that children in care are no longer commodified.