FIGHTING FOR
CHILDREN'S RIGHTS
IN INSTITUTIONAL SETTINGS

This is an edited* version of Article 39's Director's third witness statement (July 2020) in the charity's legal action against **The Adoption and Children (Coronavirus) (Amendment) Regulations 2020** (known as Statutory Instrument 445).

*The name of the civil servant who provided witness statements for the Department for Education is omitted, together with exhibit and other references.

1. In this third witness statement I return to the fundamental dispute between Article 39 and the Department for Education ('the Department'), namely that it is our contention that the regulatory changes made in April 2020 removed and diluted core safeguards for children in the care of the state. I explore how and why the Department came to its decision to pursue extensive deregulation as the global pandemic reached our country.

2. I then summarise recent serious case reviews and cases decided by the Local Government and Social Care Ombudsman which directly concern looked after children and the weakening of the statutory framework. I also highlight three cases decided by the family court where judges expressed grave concerns about the welfare of looked after children: first in respect of the failure of the independent reviewing officer role to protect the rights of children and, secondly, concerning the national shortage of secure accommodation.

3. I next present a summary of Ofsted findings in respect of children's homes, published since the 2020 Regulations came into force, and go on to share information I have gained into children's experiences these past few months in my role as Director of a national children's rights charity.

4. The evidence I have drawn together combines to show both children's exceptionally high levels of vulnerability and the fragility of the care system when the statutory framework was intact, before the 2020 Regulations.

5. I want to emphasise that Article 39 absolutely understands the tremendous pressures facing public services, carers and professionals, and managers and policy makers, as the global pandemic unfolded. This has been our position from the start, and it was clear in our briefing to Parliamentarians on the Coronavirus Bill, in March 2020, at a time when we were unaware of the changes being planned to children's social care regulations:

   We understand that the Government must take all necessary action to protect our population at this time of crisis. However, the state must continue to do all it can to provide care and support to vulnerable children and their families. We consider the sweeping removal of local authority duties in this Bill to be disproportionate, and this has the potential to cause great harm to those who are least able to cope. There are many ways in which the Bill could be improved, with new safeguards and protections added. Given the legislation is to pass through Parliament within days, we are proposing just three amendments:

1. *The proposed watering down of statutory obligations in Schedule 11 (Clause 14) should only be applied to the extent strictly required by the exigencies of the coronavirus situation, otherwise local authorities must carry out their normal functions and duties.*
2. *The two-year period provided for in Clause 75 does not correspond to current estimates for the length of the crisis and is far longer than the periods provided for in previous emergency legislation. We support a six-month sunset clause, with the option of renewal, in order to ensure that any powers are strictly necessary.*
3. *Once passed, the Secretary of State and Chief Social Worker for Children and Families must publish a report each month setting out the impact of the health and social care provisions in this emergency legislation on children and families.*[1]

How the 2020 Regulations came about

6. The second witness statement of [name of civil servant] conveys across 15 or so pages how one part of the machinery of government – those responsible for children's social care in the Department for Education – responded to the health crisis in the early days and weeks. The account is compelling and impressive. But it does not answer the critical question, which is: why the Department for Education considered that extensive deregulation during a global pandemic, made without prior public and Parliamentary scrutiny and debate, would safeguard and promote the welfare of extremely vulnerable children in the care of the state.

7. In my first witness statement, I noted that four of the five organisations named in the Explanatory Memorandum as having been consulted by the Department about the regulatory changes denied this publicly shortly after the publication of the 2020 Regulations.

8. On 24 June 2020, the Department provided a response to a Freedom of Information (FOI) Act request made by Mr John Radoux, a child counsellor who has worked in children's homes for 16 years and was himself in care as a child. In response to Mr Radoux's question about who was "provided information on the proposed changes to children's social care regulations ahead of the publication of The Adoption and Children (Coronavirus) (Amendment) Regulations 2020", an official from the Department stated:

   We have interpreted this request as meaning 1 or more person in any individual organisation that were party to discussions that informed the Department's thinking about changes to regulations to adapt to Covid-19. They either commented on specific proposals developed by DfE; suggested possible changes or were party to email correspondence on these matters. [Emphasis added]

9. In response to the question asking for the start and end date of the consultation, the Department replied:

   There was no formal consultation therefore a start and end date cannot be provided. [Emphasis added].

10. The civil servant who responded to the FOI request is the same individual listed as the Departmental contact person in the Explanatory Memorandum which was published with the 2020 Regulations two months earlier, on 23 April 2020. That document stated:

[1] https://article39.org.uk/2020/03/23/coronavirus-bill-threats-to-childrens-rights/

The Department has consulted informally with the sector who have asked for these changes to be in force as a matter of urgency. Waiting 21 days will put extraordinary pressure on local authorities, providers and services to try to meet statutory obligations while continuing to provide care for vulnerable children and young people during the outbreak.

It was not possible to make the regulations earlier. The Government announced social distancing guidance on 16th March, then introduced 'stay at home' rules on 23rd March. The Department was not in a position to assess the extent and impact of the 'stay at home' rules on children's social care immediately and needed to consult with the sector to understand the impact and practical difficulties local authorities would have in administering their duties.

11. Having reviewed the latest material provided by the Department, and returned to documents released earlier, I can see no evidence that the genesis of the 2020 Regulations is that senior leaders "asked for the relaxations". Rather, as [name of civil servant] second witness statement explains, the decision to consider a "long list of potential changes" to children's social care regulations was taken by the Department in March, and the detailed work began on 19 March 2020.

12. Accordingly, the 17 March 2020 email from the Department to 20 local authorities and voluntary adoption agencies stated:

    We are looking reviewing [sic] all relevant children's social care regulations to identify any areas that we need to amend to allow for flexibility in the coming months…

13. The Department's decision to review "all relevant social care regulations" in the face of the global pandemic is, I believe, indicative of a dangerous mindset that has developed over recent years which conceives of the statutory children's social care framework as a 'burden' to local authorities that stifles professional freedoms and innovation. This is why the Department's recent unsuccessful attempts to remove statutory duties are pertinent to the 2020 Regulations. It appears to me that deregulation was an instinctive response to COVID-19 by the Department because the significance of the safeguards are no longer appreciated at the highest levels.

The fundamental dispute

14. The Defendant's detailed grounds essentially frame the source of this claim to be a disagreement between Article 39 and the Department over:

    … the best way to safeguard the interests of vulnerable children in the unprecedented circumstances of the COVID-19 pandemic. In the claimant's view, the best way to do so would be to strictly maintain the time limits and other provisions in the amended regulations, regardless of the pressure placed on children's social care services by sickness absence and other factors. The Secretary of State disagrees, and took the view that in these circumstances there needed to be a degree of prioritisation on the basis of risk and need.

15. With respect, I believe the fundamental dispute is whether the legal protections put in place by successive governments, from the 1940s onwards, are core safeguards for children or second-level administrative processes. Article 39 contends that they are core safeguards, which is why we have opposed the 2020 Regulations from the start. In contrast, although the Department has conceded they are "important", its descriptions of

the legal provisions which it has diluted or removed altogether show a well-established, alternative view – that they are, for all intents and purposes, bureaucratic hindrances. I believe it is this profound difference which has led Article 39 and the Department to reach differing conclusions of the risks to vulnerable children brought by the 2020 Regulations.

16. In the 6 April 2020 briefing to Ministers, the regulatory changes are described as follows:

    Most changes will ease administrative burdens, allow visits and contact to take place remotely and relax strict timescales where possible. These are low risk changes and will provide more flexibility to focus on core safeguarding responsibilities.

    We are therefore proposing to keep in place requirements to do with essential safeguarding … The duties we propose to amend … can be done with minimal risk.

17. Giving evidence to the Education Select Committee on 22 April 2020, the Children's Minister, Vicky Ford MP, was asked whether the Department would learn from the suspension of statutory duties during COVID-19, in order to "[free] people up to do more useful things in future":

    ***David Simmonds**: Minister, coming back to this point about statutory duties, a review by the Department has found that some of [the] statutory duties are leading to local authorities having to undertake activities that are not useful or purposeful, in particular, some of the reviews that are required under the statutory duties—help by foster carers, prospective adopters, the children in the care system—are found not to have improved their experience. Is the Department learning, and will it learn, from the suspension of any of those statutory duties, to see where it has exposed the fact that they were not leading to purposeful activity, with a view to dispensing with those statutory duties and freeing people up to do more useful things in future?*

    ***Vicky Ford**: That is exactly the point, David, about why we are laying in place the statutory instrument in order to implement flexibility on certain statutory duties. We are focused on giving that flexibility on the lower risk areas in order to make sure that the experts on the ground can be focused on what they need to do now. [Emphasis added]*

18. The Explanatory Memorandum accompanying the 2020 Regulations describes the changes as:

    The changes prioritise the needs of children, whilst relaxing some administrative and procedural obligations to support delivery of children's services but maintaining appropriate safeguards in such extraordinary circumstances. [Emphasis added]

    The instrument will make temporary changes to provide additional flexibility for local authorities, providers and services to meet statutory duties whilst maintaining appropriate safeguards. These are low risk changes to ease administrative and procedural duties and are required to ensure stability of children's social care during the outbreak. [Emphasis added]

19. During the 10 June 2020 annulment debate in the House of Commons, the Children's Minister further stated:

    The regulations on children's social care are intended to support local authorities and providers, but do not remove any fundamental protections … We have made no changes

to primary legislation and the vast majority of secondary legislation has remained unchanged. [Emphasis added]

20. [Name of civil servant] second witness statement indicates that a table entitled 'COVID-19 Children's social care: potential regulatory changes', began to be developed on 19 March 2020, and was considered by senior managers, including the Chief Social Worker for Children and Families, on 23 March. This is the only document I have been able to find which suggests that civil servants were asked to consider the potential risks to children of each proposed regulatory change. The table has 11 columns with the following headings;
    - Issue
    - Regulation
    - Policy Owner
    - Comments
    - Does the provision actually need amending or is there enough flexibility / discrection (sic) to mean amending is not essential?
    - If it needs amending, what should it be amended to?
    - How long should the amendment remain in force?
    - When should the amendment come into force?
    - Unintended consequences
    - Comms/handling
    - Cost implications

21. It is the column headed 'Unintended consequences' where I would expect the potential risks to children to be documented. The column remains blank, however, for the majority of the regulatory changes listed in the table. Where entries do exist, they are in very brief note form. For example, in relation to the changes around social worker visits to children who are privately fostered, the table highlights the risk of "System not working as we intend it to". Possible unintended consequences of suspending the duty to have adoption panels and to visit children in their adoptive placements include "That adopters are approved without thorough consideration" (though civil servants thought "the risks are low") and "a child in placement being at risk of harm" (again the risk was said to be "low"). In relation to the statutory complaints procedure, the possible unintended consequences are said to be "LAs may use the relaxation in timescales as an excuse not to be as prompt in fulfilling their duties… This may cause unnecessary delays…".

22. In the absence of an overarching document showing the outcome of internal and external discussions in the run-up to the drafting of the 2020 Regulations, it is difficult to make sense of the decision-making process. For instance, in the [Table headed COVID-19 Children's social care: potential regulatory changes], the civil servants who completed the row on potential changes to care leaver regulations indicated that it was necessary to retain the statutory timescales for visits from personal advisers, since "we have concerns about the quality of some (unregulated) provision that relevant children are accommodated in and therefore believe it is important to retain the requirement to visit within 7 days where young people move into accommodation". How was it that the Department came to a view that 16 and 17 year-olds who move from care to independent accommodation still require a visit from their personal adviser within 7 days, and therefore this set of regulations was left intact, while simultaneously a decision was taken to weaken the statutory scheme for social worker visits to children of any age who are still in care and move to a new placement? The Department's own data, published in February 2020, showed there were 90 children aged 15 and under in unregulated accommodation. Further, in my first witness statement, I noted that the Department's own

statistics show that looked after children were moved from 1,100 placements in 2018/19 due to a child protection or standard of care concern.

23. The next section of my statement seeks to demonstrate that the statutory framework in place before the 2020 Regulations was an ecosystem of essential and interdependent safeguards for very vulnerable children.

Serious case reviews – introduction

24. Serious case reviews were held when a child died or suffered serious harm and abuse or neglect was known or suspected.[2] From March 2018, these were replaced by local child safeguarding practice reviews[3] though the criteria remains the same.[4]

25. I have identified five cases published by the NSPCC in 2019 and 2020 which highlight the extreme vulnerability of looked after children and the necessity of the statutory framework (pre-2020 Regulations). The five cases concern 14 looked after children, two of whom died and a third who almost died. The other 11 children were sexually abused by their male foster carers.

26. In 2015, the national panel of independent experts on serious case reviews recommended that the Department for Education "monitors emerging themes" from serious case reviews to inform national policy development.[5] Had there been any public consultation on the 2020 Regulations, I believe social work professionals and organisations would have submitted evidence of learning from child deaths and serious harms suffered by children in care in support of the retention of key safeguards, such as adoption and fostering panels, social worker visits, six-monthly statutory reviews of children's welfare, independent visits to children's homes and senior manager scrutiny and oversight.

27. Notwithstanding the lack of public consultation, it is important to note that the Chief Social Worker for Children and Families, who appears to be the most senior civil servant directly involved in the 2020 Regulations, has been a member of the statutory Child Safeguarding Practice Review Panel from its inception in June 2018.[6] The Panel's function is to identify serious safeguarding matters which require a national review. Membership of this important national body inevitably demands alertness to the emergence of themes and patterns in the serious harms suffered by looked after children. More fundamentally, I would expect the Chief Social Worker to understand the importance of statutory safeguards for vulnerable children – individually and interdependently – and to exercise the utmost caution in facilitating their removal or dilution. In all of the documents released through the disclosure process, I have seen no evidence at all that the Chief Social Worker contributed professional social work knowledge and learning to the process which led to the radical deregulation of safeguards. This is particularly important in the light of the Department for Education's decision not to consult the Children's Commissioner for England or organisations like Article 39 which promote and protect the rights of looked after children and have safeguarding expertise.

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[2] Regulation 5, The Local Safeguarding Children Boards Regulations 2006.
[3] S16F Children Act 2004 (as amended by Children and Social Work Act 2017).
[4] Department for Education (July 2018) Working together: transitional guidance statutory guidance for Local Safeguarding Children Boards, local authorities, safeguarding partners, child death review partners, and the Child Safeguarding Practice Review Panel.
[5] Second report of the national panel of independent experts on Serious Case Reviews, November 2015, page 10.
6 https://www.gov.uk/government/news/members-announced-for-new-child-safeguarding-practice-review-panel

Lessons from five serious case reviews

Vulnerability of a child placed in an 'independence unit'

28. One of the latest reviews to be published (July 2020) concerns 'Sasha',[7] who entered care for the second time aged 17. She had been the subject of a child protection plan as a young child, and had also been in foster care aged 6-7 years, and the subject of care proceedings then. Now, in her teenage years, there were serious concerns that Sasha was being exploited, she had reported substance misuse, violence from her former boyfriend, anxiety and panic attacks and was no longer doing well academically.

29. On becoming looked after for the second time, Sasha was placed in an 'independence unit' with just five hours staff support a week. These unregulated placements are not, by law, permitted to provide care to looked after children (establishments offering both care and accommodation must register as children's homes with Ofsted and follow the children's homes regulations). The serious case review notes this was "the type of service thought to be appropriate for a young person of [Sasha's] capabilities".

30. On realising that Sasha was not safe in this unregulated accommodation ("there was no 24-hour staff presence"), children's social care decided she had to move to a different independence unit outside the local authority area. Sasha did not want to move. She asked the local authority to wait until her independent reviewing officer (IRO) returned from leave; and said her IRO had told her she could stay in the unit until she was 21 years old. The local authority pressed on with the move because of concerns about Sasha's safety. She moved to the second unit at the beginning of August 2017. In the middle of that month, on a Sunday, Sasha's friend visited her. She was upset but the friend "was not permitted to stay beyond visiting time". Later that evening Sasha was found hanging in her bedroom. She died three days later. Professionals who worked with Sasha said she was "highly intelligent, articulate, respectful of authority, mature for her age, proud, self-assured, determined, confident, engaging and friendly". She had plans to become a lawyer.

31. The serious case review author questions whether Sasha's "seeming maturity and competence was perhaps 'pseudo-maturity'". One of his recommendations is that risk assessments are undertaken before looked after children are placed in private and voluntary independence units. Article 39's view is that looked after children should never be placed in settings where there are no professional carers. While these unregulated placements continue to be permitted, it is all the more important that looked after children have close and regular contact with their social workers and that the role of the IRO in enabling the child's wishes and feelings to be heard and understood – through the statutory review process – is respected. Had there been a public consultation on the 2020 Regulations, Article 39 would have raised the plight of the 6,000+ looked after children in unregulated accommodation and urged the Department to introduce at least some temporary legal protections – such as requiring providers to notify serious child welfare incidents to the Department or Ofsted. The Defendant's detailed grounds state it is "wholly unrealistic to suggest that [legal protections for looked after children] could have been strengthened at this time, in circumstances where such high levels of workforce absence were predicted". Yet other parts of the government machinery did introduce substantial new legal protections – relating to statutory sick pay, evictions, universal credit sanctions, tax credit entitlements, childcare payments and so on.

[7] Sasha's family chose this name for the serious case review.

Relationship with social worker is key

32. This 2020 serious case review explains that, in May 2019, “Georgia was admitted to hospital after a serious and life-threatening overdose”. She was aged 15 years. Georgia had entered care the previous year, in 2018, and was the subject of a care order and placed with connected foster carers. She had been known to children’s social care from the age of two. The serious case review states she was “extremely vulnerable due to the abuse and neglect she had experienced, and this was not always fully acknowledged by those working with her”. Georgia took the life-threatening overdose while living with her father, to whom she had only recently (over the past six months) been reunited after a decade apart. This was her second overdose at his home; the previous occasion was around a month before when she also self-harmed with a knife. Quoting research by both the Children’s Commissioner for England and Coram Voice, the review identifies frequent changes of social workers as an area of concern: “There is a need for children in care to build a relationship with the professionals working with them. The relationship with their social worker is key, particularly when there is instability of placement and school”. Although it is primary legislation which requires that local authorities (social workers) visit looked after children, it is through The Care Planning, Placement and Case Review (England) Regulations 2010 that children gain specific entitlements to see their social worker in private at regular intervals (unless they are in a long-term foster placement and they have agreed to only two visits a year). Similarly, it is only through these 2010 Regulations that the local authority is duty-bound to convene a review of the child’s care when, as a consequence of a social worker visit, the child’s welfare is found not have been adequately safeguarded and promoted.

Being in the child’s corner

33. Child F entered care at the age of seven following abuse and neglect, though she had been known to statutory agencies from infancy. The year after entering care, she was diagnosed with a growth hormone deficiency. Aged 13 and 14, Child F attended six medical appointments – two with her GP and four at Accident and Emergency. She was convinced she was seriously ill, and communicated this to her foster carers and several professionals. She was vomiting, having regular dizzy spells and was unable to eat. She alleged that her foster carer had kneed her in the back and pushed her when she was unable to stand up.

34. Her foster carer was of the view that Child F was fabricating illness. At the fifth visit to A&E, when Child F was now with respite foster carers (her long-term foster carers having asked for her to be moved), she was diagnosed with an aggressive Grade 4 brain tumour. She underwent brain surgery and radiotherapy and chemotherapy and then spent her final months in a hospice. She was just 14 when she died and professionals now concede she had been seriously ill for a period of 10 months. The case review inevitably highlights that Child F was not properly listened to and observes:

    Child F did not have anyone in their corner who was challenging the picture presented by the Foster Carers. To truly understand this we have to ask what in similar circumstances would any reasonable parent have done if their child was presenting with the same symptoms as Child F. It is likely that the majority of parents would advocate on their child’s behalf and ensure that there was a challenge to health professionals. They would not accept an explanation which did not fit with their perception of what was happening; parents would shoulder the burden so the child did not have to. There were a number of professionals who had contact who could have advocated for Child F and escalated

concerns but failed to do so. There was a lack of professional curiosity and challenge by all professionals.

35. It is my firm professional view that relationships between children and their social workers are only able to develop through regular visits and contact, and that social workers who have such relationships with children are far more likely than those who don't to be in the child's corner.

Necessity of robust supervision of foster carers

36. This serious case review concerns the conviction of a male foster carer of 13 counts of sexual assault against three girls in his care – Grace, Lisa and Carey, who are now adults. He was an approved foster carer (with his wife) from 1998 to December 2014. A total of 38 children were placed with this couple; 10 of these after 2011, which is when Grace (by this time an adult) had told her GP, and then a social worker, that she had been sexually abused by her male foster carer between the ages of 14 and 17.

37. Lisa was placed with these foster carers in 2013 and was moved the following year, aged 13, after she reported she had been sexually abused by the male foster carer. Carey was sexually abused by the same foster carer over a period of four months; she reported this in 2014. Carey did not tell anyone until she was interviewed following Lisa's disclosure: she said the foster carer had warned her he would be stopped from fostering and be sent to prison if she told anyone of the abuse.

38. The author of the serious case review indicates "there can be no confidence" that other children were not abused in this foster placement. He identifies the barriers which children generally face in telling adults about sexual abuse. The challenges for looked after children are even greater:

    Children who need to be looked after are particularly vulnerable to sexual abuse due to the adverse circumstances many will already have experienced including poor attachment and neglect and represent additional opportunity to a perpetrator who is able to pass the vetting and assessment process for becoming a foster carer.

39. Lessons highlighted include: the necessity of robust monitoring and supervision of foster carers (warning that long-established relationships between the supervising social worker and carers can make it harder for children to raise concerns); social workers spending quality time and building meaningful relationships with children; and local authorities acting on lower level concerns about the care of children. The author observes:

    A system of statutory checks and ongoing oversight arrangements of the child's care and progress are intended to ensure that care is not just safe but that it nurtures the overall development of the child. The arrangements that are now in place in 2018 for the approval, monitoring and care of children are more rigorous and extensive than when the perpetrator was first approved in 1988.

40. Had this serious case review been completed after 24 April 2020, when the 2020 Regulations had come into force, I do not believe the author would have been able to make the concluding statement above. This is because:
    a. Statutory timescales for minimum local authority (social worker) visits to looked after children have been diluted (at the same time as permitting these to take place by telephone or video call or some other electronic means);

b. The duty to review each child's welfare and care every six months has been removed (after the child's second review, at three months, the requirement now is "where reasonably practicable thereafter");
c. Since children often access independent advocates to help them express their wishes and feelings at their six-monthly statutory reviews, the removal of this duty inevitably weakens the advocacy safeguard as well;
d. Fostering panels, with members who are independent of the fostering service, are no longer mandatory;
e. The requirement to undertake reviews of foster carers every year has been removed (after the first review it is now "whenever the fostering service provider consider it necessary").

The interdependent nature of safeguards

41. This 2019 serious case review concerns the sexual abuse of eight primary school children by a male foster carer, who was convicted of these offences in 2016 and 2017. The child victims of the crimes, which included rape, sexual assaults and voyeurism, were between 1 year and 11 years old at the time of the offences. Although a child in this foster placement had alleged abuse in 2012, and there were other signs of sexual abuse (for example, two pre-school aged girls had soreness of the vulva), it was not until 2014 that the male foster care was arrested and he was imprisoned in 2016.

42. The serious case review explores similar territory to the Grace, Lisa and Carey review above – the approval process and annual reviews, the fostering panel, training, placement decision-making (particularly in emergencies), the role of supervising social workers and children's social workers and the safeguarding board's quality assurance function. Checks and balances within the system, often required by regulations, did not protect children: "Key safeguards were insufficiently robust". Areas of learning include:
    a. Foster carer assessment and approval process must be rigorous and able to identify risk factors;
    b. The needs of individual children must determine placement 'matches' and decision-making, rather than simply the availability of such placements;
    c. Need for more robust requirements around training;
    d. Supervising social workers must be ready (and supported) to challenge;
    e. Annual foster carer reviews must be thorough, particularly when concerns have been raised.

43. In relation to social worker visits to children, the author references an earlier (2014) serious case review which similarly concerned the sexual abuse of five young children in foster care. That 2014 review found "there was insufficient direct contact between the children and the social workers who were allocated by the local authority to work with them. This 2019 review repeats the same conclusion:

    Looked after children may not be able to talk to social workers about all of the most difficult issues in their lives. However it is absolutely essential that the child should see the social worker as someone who is reliable, has a good knowledge of his or her past, knows the important people in the child's life, observes the child carefully, asks thoughtful questions, listens to their views and explains things clearly. If a child has something very distressing to tell, they may well not choose to disclose it to the social worker, but they need to have a strong sense that the social worker is part of a group of people around the child who can understand and deal effectively with troubling information. That would significantly increase the likelihood of the child choosing to tell someone.

44. As for the six-monthly statutory review (removed by the 2020 Regulations), the serious case review author notes the changing statutory and practice framework though found significant gaps in the implementation of these:

    Activity to ensure that the voice of the child has been heard should come together through the looked after review (LAC review). Regulations require that each looked after child has a review within defined periods after coming into care and then at least every six months. The purpose is to ensure that there is an agreed care plan, the child (among others) has contributed to it, and that it is being implemented in a purposeful way. Over recent decades expectations in relation to reviews have changed, requiring greater opportunities for children and young people to contribute to reviews, both at meetings and in individual dialogue with social workers and reviewing officers and more independence in the chairing and oversight of reviews. More recently reviewing officers are expected to have some contact with looked after children and monitor their care plan between review meetings.

    The LAC reviews of children placed with the foster carers took place over a period of 14 years during which different expectations applied. Until late 2002 most reviews would have been chaired by team managers (or in some instances by social workers themselves) who had limited independence. Even as new standards were implemented it is not always possible to find evidence of good practice.

45. One of the recommendations of the serious case review is that the local authority must assure the safeguarding children board (since replaced by safeguarding children partnerships) "that its systems for care planning and safeguarding for looked after children keep them safe". This serious case review, as with the others, demonstrates unequivocally that the regulatory framework in place for looked after children is made up of inter-related safeguards. Serious case reviews invariably assess the extent to which legal protections have been implemented by local authorities and other agencies.

Faults found by the Local Government and Social Care Ombudsman (LGSCO)

46. The cases I summarise below, all decided in 2019 and 2020, further illustrate the ecosystem of safeguarding legislation and mechanisms – with children, young people and carers relying, first, upon the existence of statutory duties to challenge unmet needs; secondly, having the legal right to make a complaint, and to request that it be independently investigated; and then, if necessary to take unresolved matters to the LGSCO. In its review of the Children Act 1989 statutory procedure, published 2015, the LGSCO observed:

    Councils provide thousands of children and young people with crucial support services during difficult and sometimes traumatic times. Some types of support that can make a real difference to children's lives include providing care to those who are no longer able to be looked after by their parents, accommodation for potentially homeless young people and safeguarding against harm. Clearly, these are sensitive and complex areas so if things go wrong it is essential that problems are dealt with swiftly and openly.

47. There is also the right to seek to bring judicial review and Human Rights Act claims and, in this regard, I note the statement from a representative from the Association of Directors of Children's Services in their 23 March 2020 correspondence with the Department: "We must do all we can to protect LA from legal action after all this is over – it will cripple LA budgets if they're having to deal with JR etc".

48. The 2020 Regulations have effectively removed the timescales of stage 3 children's social care complaints investigations. This not only risks impeding timely resolution of local authority failures to meet their statutory obligations towards vulnerable children; it also has the domino effect of stalling access to the LGSCO.

Residential care, foster care and leaving care

49. In February 2020, the LGSCO found fault in the care and support given to a looked after child who was placed in residential care in a different authority by Herefordshire Council. He was returned to his home area, and back to his mother's care, but there was no proper assessment or plans to meet his needs. The local authority had not met its responsibilities as a corporate parent in respect of the boy's educational needs and rights (he had a statement of special educational needs, which the local authority he was living in – while in residential care – allowed to lapse and this was not challenged by his corporate parents). The LGSCO found the boy was "put at risk and did not receive appropriate care and interventions from social workers between 2013 and 2017". The independent (stage 3) panel convened to investigate his mother's complaint had earlier found "there appear to have been significant periods of time when [the boy] was in care but not seen by his social worker. For some of that time he was in a residential setting deemed to be inadequate by OFSTED".

50. A case decided by the LGSCO in January 2020 concerned a child in long-term foster care. The complaint was made by his grandmother and his mother. One aspect concerned contact arrangements, and the failure of Birmingham City Council to fulfil its obligations – including a contact visit which did not take place on the child's birthday. The local authority's prior investigation (under the statutory children's social care procedure) had upheld this element of the complaint. Of note is that one of the agreed outcomes of the LGSCO's investigation was that the local authority would "review contact through [children in care] meetings going forward as a standing agenda item". This is a required area of consideration for children's statutory reviews[8], though the 2020 Regulations have removed the duty to undertake these six monthly reviews (after the first two reviews held first within 20 days of the child entering care and then within three months).

51. In March 2020, the LGSCO decided the case of a care leaver who had complained to his local authority, the London Borough of Newham, about the unsuitability of accommodation he was placed in post-16 and financial support as a child in care and a care leaver. The LGSCO found the council was at fault for not investigating his complaint through the children's social care statutory procedure. I fear the 'relaxation' of the independent, stage 3, element of the statutory procedure will further compound children's difficulties in having their complaints properly responded to.

Adoption support

52. The five adoption cases below, decided by the LGSCO in 2019 and 2020, underline the importance of statutory obligations for (adoptive) parents being able to secure help to meet their child's needs. They additionally highlight the importance of the independent element of the statutory complaints procedure.

53. In 2017, a foster carer of many years' experience applied to adopt a child, who is "profoundly disabled". She said she could only do this if the child's usual package of support continued, including her 56 days a year respite (short breaks). The foster carer

[8] Schedule 7, The Care Planning, Placement and Case Review (England) Regulations 2010

does not live in the same local authority as the child's corporate parent (Wolverhampton City Council). There was ongoing dispute about Wolverhampton City Council's legal duties to provide adoption (financial) support, and the foster carer progressed her complaint to stage 3 of the children's social care statutory procedure. The stage 3 independent panel recommended the local authority review its adoption support policy and specifically include support for disabled children placed out of their home area. As this hadn't been implemented, the LGSCO was able to secure an agreement from the local authority that such a policy would be produced within three months, and apologies would be given to both the foster carer and the child within a month. The case concluded in October 2019.[9]

54. A similar case, decided in May 2019, concerned a child who was adopted as a baby and then, aged around five years old, showed "dramatic" behavioural changes. The local authority, London Borough of Harrow, was found to be at fault: for putting the child "at risk of harm" by the delay in meeting her therapeutic needs; for the delay in arranging an assessment for an Education, Health and Care Plan; for not providing clear information and advice on post adoption support; and for not following the children's social care statutory procedure. The council agreed to pay compensation to the child and the adoptive parents.[10]

55. A case decided by the LGSCO in August 2019 concerned the placement of two children for adoption with carers not from their home area. Liverpool City Council failed to fulfil the adoption support plan, which included not arranging therapy for the children. The children received just one visit from their social worker in over seven months. The local authority had refused to progress the carers' complaint to stage 3 of the children's social care statutory procedure.

56. The carers said that "the problems delayed their applying to the court for an adoption order because, as the Council was not giving the help it should, they feared it would do even less if the adoption was finalised"; the LGSCO said their concerns were "understandable". As a result of the investigation, the council agreed to pay compensation to the carers and to the children and to take action to remedy the faults identified by the LGSCO, including in relation to the children's therapy, lack of social worker visits and the statutory complaints procedure.[11]

57. This fourth adoption case elucidates the importance of 'matching' children with the right adoptive parents, and ensuring proper support is given to adoptive families. An adoptive parent complained to the LGSCO that Suffolk County Council did not obtain medical information from her (adopted) child's birth parents. When she had applied to adopt, she had specifically said that she would be unable to parent a disabled child, given her accommodation and that she was a single parent. Concerns about the child's health and development transpired only after his adoption, and the family had to move to a bungalow due to his restricted mobility. His (adoptive) mother struggled financially in making this move and asked the council to fund the moving costs. In response, the local authority offered a monthly adoption allowance until the child's 18th birthday but no support for the move. The LGSCO could find no statutory entitlement to such support. However, the council agreed to pay £1,000 "to recognise the anxiety, frustration and distress caused by its failure to provide the information she is entitled to concerning the birth parents' health and social care background over a period of more than two and a

9 https://www.lgo.org.uk/decisions/children-s-care-services/adoption/19-000-899

10 https://www.lgo.org.uk/decisions/children-s-care-services/adoption/18-014-935

11 https://www.lgo.org.uk/decisions/children-s-care-services/adoption/18-006-427

half years", to access the health and social care records of the child's birth parents, to share information with his (adoptive) mother and to amend its placement planning template to include outstanding health issues. The case was decided in July 2019.[12]

58. Finally, a case decided by the LGSCO in November 2019 illustrates the struggles adoptive parents can go through to resolve basic matters such as children seeing their siblings and securing a child's entitlement to a government savings scheme. The London Borough of Hounslow was found to be at fault for not arranging contact between two siblings who had been adopted and their youngest sibling who had been adopted by different parents. It also failed to provide sufficient financial support and there was delay in sorting saving accounts for the children. The local authority agreed to apologise and to review its policy and procedures.[13] As with all of the other cases I summarise above, the adoptive parents were only able to secure the help they needed because the LGSCO found there were statutory duties that had not been implemented.

Cases before the family courts

59. Three cases before the family court, two in 2018 and one in 2020, further evidence the importance of the pre-2020 Regulations statutory framework in safeguarding and promoting looked after children's welfare.

60. The first concerns two sisters for whom care proceedings were started in 2003, though it was not until 2008 that care orders and placement orders were made for them. The girls were to be adopted together but lived with the same foster carer (who had expressed a wish to adopt them) until, respectively, 2013 and 2014. Both girls suffered numerous placement moves, changes in social workers and sexual exploitation. The local authority accepted their Article 8 rights were breached, and they were awarded damages. Mr Justice Keehan said, **"**The care of and care planning for both these young people by Herefordshire Council has, over the last ten years or so, been woeful" and was particularly scathing of the failings of the independent reviewing officer (IRO) function:

49. I make no apology for having set out the statutory and secondary legislative provisions and the guidance at such length. Taken as a whole they set out the hugely important function that an IRO performs to ensure that a looked after child is well served and whose needs are met by the local authority as his or her corporate parent.
50. I am appalled at the manner in which and the serial occasions on which the social workers and their managers have failed these two young people. The fact that I have chosen in this judgment to focus on the role and actions of the various IRO's should not be taken in any way to diminish the failures of the social workers and/or their man[a]gers in this case. Rather the failings of the IROs has been so stark and grave that, in my judgment, it was appropriate to focus on the failings of the IROs and the IRO service in this case.

51. Once a court makes a care order it entrusts, as by statute it must, the future care of the child to the local authority. The essential safeguard the court and the public at large have that a local authority will be a good corporate parent is the function and role of the IRO. Any obstruction of an IRO performing their statutory role or any diminution in an IRO, or their manager, feeling empowered to do so, is a matter of the utmost consequence. For otherwise a looked after child is subject to the vagaries of social work practice and the local authority's different pressures and priorities. The IRO is, or should

12 https://www.lgo.org.uk/decisions/children-s-care-services/adoption/18-011-493

13 https://www.lgo.org.uk/decisions/children-s-care-services/adoption/17-018-529

be, the child's protector or advocate. If the IRO is silenced or pressured not to act as the child's interests demand and require, it is the child who will suffer – just as these children, A and B have suffered.[14] [Emphasis added]

61. Mr Justice Keehan decided another case in November 2018, also relating to Herefordshire Council. It concerned the separation of twins for whom the family court had made care and placement orders when they were five, with the expectation that they would be adopted together. A little more than a year after the court made its orders, the local authority decided to separate them. Mr Justice Keehan said, "The catalogue of the local authority's errors and failings in this case is troubling and hugely lamentable". He highlighted:

    … the complete and utter failure of the IRO service to satisfy any of its statutory duties in respect of BT and GT. The IROs and the IRO service did absolutely nothing to protect and promote the welfare best interests of the children and did nothing to challenge the local authority's dreadful and, at times, irrational decision making and care planning.[15]

62. The local authority's Assistant Director of Children's Services compiled a comprehensive list of admitted failures in meeting their statutory obligations to the twins. This is attached to the judgment and sets out the wide-ranging actions the local authority has taken, and will take, in consequence. These changes to policies and procedures include a number of measures pertinent to those aspects of the 2020 Regulations we specifically challenge, including:
    a. A commitment that any proposal to separate twins in future will be put before the adoption panel;
    b. Children's six-monthly "legal review" will ensure the authority's decision-maker (a senior social worker) is involved in decision-making;
    c. Children's six-monthly "legal review" will ensure sibling contact arrangements;
    d. The local authority's IROs have been issued with guidance (by email and a laminated copy) which, among other things, stresses "The primary task of the IRO is to ensure that the care plan for the child fully reflects the child's current needs and that the actions set out in the plan are consistent with the local authority's legal responsibilities towards the child. Their duty is to challenge poor corporate parenting".

63. The case of 15 year-old Samantha, for whom there was no secure accommodation anywhere in England, shows the extremely fragile nature of the care system and the wider context of this claim. Mr Justice Cobb stressed that this lack of provision for very vulnerable looked after children is not related to COVID-19:

    The crisis caused by the coronavirus COVID-19 pandemic will plainly have impacted on the provision of secure accommodation at present, and made the task of finding a bed in a secure unit for Samantha yet more difficult. But I wish to stress that the problems raised in this case are not related to the pandemic. The absence of satisfactory secure provision is a chronic problem, which in recent years has become ever more acute to the significant detriment of a large number of very damaged young people in our society. It should not be forgotten that in this case, as I point out above, [East Riding of Yorkshire Council], has been looking for a place for Samantha since well before the pandemic arose.[16] [Emphasis added]

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[14] A & B (care orders and placement orders - failures) [2018] EWFC 72

[15] BT & GT (Children: twins - adoption) [2018] EWFC 76

[16] S (Child in Care. Unregistered Placement) [2020] EWHC 1012 (Fam)

64. Following unsuccessful placements with family members, with foster carers, in children's homes and in one secure unit, in late 2019 the High Court authorised, for the first time, deprivation of liberty in accommodation other than secure provision. At that time Samantha had experienced 15 moves in 12 months and had lived in "7 different unregistered children's homes". During these latest proceedings, she was staying in a holiday cottage rented solely for the purpose of accommodating her. The local authority, East Riding of Yorkshire Council, was "doing its best for Samantha", Mr Justice Cobb said, but could find no suitable secure accommodation for her.

65. The judge directed that a copy of the ruling be sent to the Education Secretary, the Chair of the Residential Care Leadership Board, the Children's Minister and the Chief Social Worker to "raise awareness" of the plight of children who need secure accommodation but, due to nationwide shortage, are instead accommodated in unregulated or unregistered placements. He explained:

    17. I recognise that many local authorities, including [East Riding of Yorkshire Council], simply do not have sufficient provision locally to meet the needs of all of the children who require accommodation. All those working in the Family Court are familiar with the situation of a child who at a point of crisis is placed, or is to be placed, in an unregistered children's home, as an often unavoidable, urgent and temporary measure. The urgency of a situation, however, does not truly make it any more acceptable.

Ofsted monitoring reports on children's homes

66. I have reviewed Ofsted reports in respect of children's homes published since 24 April, the date the 2020 Regulations came into force. All of the monitoring reports referred to below were published following inspector 'visits' held remotely due to COVID-19. The majority provide further evidence that Regulation 44 visits are a safeguard in themselves, and a means by which Ofsted discharges its own safeguarding function.

67. A children's home run by Wolverhampton City Council failed to alert Ofsted to serious incidents. These only came to light because of Regulation 44 reports which are sent to Ofsted:

    The registered manager has not notified Ofsted about serious incidents in the home. For example, on one occasion a child was assaulted by a peer and complained to the police. On another occasion, a child was so seriously assaulted that she was concussed. These incidents were only notified to Ofsted when the inspector identified them in the regulation 44 reports and contacted the provider.[17]

68. In a similar vein, in May 2020, inspectors conducted a monitoring visit of a children's home for profoundly disabled children, run by the charity Chailey Heritage Foundation, "due to concerns from the independent visitor's reports and other feedback received by Ofsted".[18]

69. In July 2020, Ofsted published the outcome of its monitoring visit to a children's home run by Wolverhampton City Council. In relation to Regulation 44 visits, inspectors found:

    The independent visitor does not always seek consultation with other professionals or parents/carers to inform his view about the young people. There is no reference in the

17 https://files.ofsted.gov.uk/v1/file/50152769

18 https://files.ofsted.gov.uk/v1/file/50152689

report of the independent person's opinion as to whether children and young people are effectively safeguarded and how the conduct of the home promotes children's well-being. This lack of focus during the monitoring visit by the independent visitor has an impact on the manager and the regulator's ability to assess whether young people are safe. One visit for the month of April was not conducted. As a result, information required to be shared was not provided. The visitor is employed by the local authority and therefore is not independent.[19] [Emphasis added]

70. A children's home registered to provide care and accommodation for two children who have learning disabilities received an Ofsted monitoring visit in June 2020. One of the concerns previously raised about this home, in November 2019, related to the Regulation 44 independent visitor's report. Ofsted notes in this latest report, published in July 2020, that "The action to address this shortfall has been significantly delayed. This has meant that the home has not had effective independent scrutiny, a key element for safeguarding the well-being of children, for several months" [emphasis added].[20] This same observation was made following a monitoring visit of a children's home run by Kingston upon Hull City Council in June 2020: "The independent visitor's reports do not provide enough detail and evaluation of the safety and well-being of the children. Consequently, the regulatory bodies and the management team's oversight of the children's care is hindered".[21]

71. Concerns about the reports from Regulation 44 visits were raised in another report published in July 2020, in respect of a children's home run by Shropshire Council, inspected the previous month.

    Monthly external visits by an independent person take place. The manager completed the home's most recent internal review of the quality of care provided in a timely manner. However, feedback from young people, their families and placing authorities was not included in the report and, therefore, in developing the quality of care provided for young people. This also affects Ofsted's ability to monitor the home effectively.[22]

72. Article 39's claim has necessarily focused on a "shortlist" of concerns, as to document the history of each lost or diluted safeguard, and the consequent risks to children, would potentially make the process unmanageable. We have not, for example, specifically highlighted the dangers of children's homes not being inspected. However, my review of Ofsted monitoring visits post-lockdown elicited two reports which, I believe, underline the necessity of vulnerable children's care and welfare continuing to be independently assessed.

73. It was only through a monitoring visit in June 2020 that Priory Education Services Limited notified Ofsted of its decision to close the children's home then under inspection. Children were not safeguarded, "children's disclosures of abuse or concerns" were not taken seriously, there had been a serious bullying incident as a result of staff sharing private information about the children, and children's bedrooms remained in a "poor decorative state". Local authorities (the children's corporate parents) were notified and arrangements were being made to move children as soon as possible.[23]

19 https://files.ofsted.gov.uk/v1/file/50152855

20 https://files.ofsted.gov.uk/v1/file/50152800

21 https://files.ofsted.gov.uk/v1/file/50152755

22 https://files.ofsted.gov.uk/v1/file/50152793

23 https://files.ofsted.gov.uk/v1/file/50152858

74. Similarly, it was only through an Ofsted monitoring visit in June 2020 that Barnardo's was discovered to have failed to refer a child's two allegations against children's homes staff to the local authority (as required by statutory guidance). Ofsted's report explained: "This means that these allegations were not subject to independent scrutiny or investigation". The matter was "rectified during the inspection", the report notes.[24]

Article 39's own evidence

75. Article 39 runs the Children and Young People's Advocates Network, which has over 170 members working in a variety of settings, with the majority supporting children in care and care leavers. Within the children's social care context, local authorities are required to ensure children have access to an advocate when they wish to make a representation (interpreted broadly as expressing views) or formal complaint. The independent reviewing officer role has a particular statutory duty to ensure looked after children know how to access an advocate, which means that in practice the six-monthly statutory review is often the mechanism through which children receive help from an independent advocate to raise issues of importance to them.

76. We have been running regular online sessions with advocates since lockdown began. We are also in regular email communication with advocates. After lockdown had started, when it looked like the Department would not extend the timeframe of its consultation on unregulated accommodation to enable looked after children and care leavers to contribute their views, we invited advocates and other professionals in our networks to share anonymous case studies of children and young people in unregulated provision. This invitation was made on 3 April 2020 and, in less than a week, we elicited the following information:

- A teenage girl's baby was removed from her after a "shocking" lack of support. Staff threatened her every day with the loss of her baby. They continually criticised her. An experienced worker told us the girl would have thrived in a family setting and that "all she needed was a Mum-like figure".
- A 16 year-old girl was moved from her residential home into semi-independent living. The two placements were around 20 miles apart, and many miles from her family who are very important to her. The support given to the girl whilst in residential care was of good standard and her behaviour and mental health improved significantly. She had activities, 1-1 time, clothing allowance, spending money and meals prepared for her. When she was moved to semi-independent living, the support decreased to virtually nothing in her eyes and she was spending all of her time at her mum's house because she felt lonely. The young person's opinion was that no one helped her adjust to her semi-independent placement and that there was no middle ground on which bits of support were taken away gradually. Eventually the semi-independent placement broke down as the young person began to break more and more rules and she is now in another residential placement which is in her home town.
- One child in supported accommodation was refused bedsheets and had to sleep on the sofa.
- We were told of accommodation not being safe for a care leaver and their young children (extra resources were required, which were either not provided or there was a delay in providing them).
- We heard of young people being placed in accommodation in an area far from their place of education or work, or out of reach of the health services that they are currently engaging with (mental health services and outpatient hospital services).

24 https://files.ofsted.gov.uk/v1/file/50152714

- We were told of problems with accommodation not being of a suitable living standard, e.g. unhygienic, poorly decorated, without basic items causing a delay in a young person having access to white goods and basic furniture.
- Examples were given of care-experienced adults being expected to keep the accommodation in a tidy and clean state (being checked on twice a day in one case) when the accommodation was not given to them in this state.
- We heard of managers refusing children access to advocacy in supported accommodation.
- One advocacy service has helped challenge the threat of eviction for 'antisocial behaviour'. We were told "The lack of transparency and the intimidation sometimes used towards vulnerable young people by housing officers has been shocking". Young people have reported that the presence of advocates has made a difference to how housing providers treat them.
- Another service has supported two young people, both aged 17, who live in the same house and raised concerns about both the practical care environment and support they have been provided. The house and its appliances are in a very poor state of repair and there are numerous concerns about staffing.
- An advocate told us that poor accommodation "is having a significant impact on the mental health of the young people and adults that we work with" and concluded: "For me, it comes back to the question to the local authority as the corporate parent that, if this was your son or daughter, would you ask them to live in accommodation like this? I suspect the answer would be 'no'".[25]

77. In June 2020, we submitted evidence to the Education Select Committee which gave an overview of how advocates have adapted their work during lockdown, and highlighted some of the issues they have been dealing with on behalf of children and young people.

78. Similar to other professionals, advocates have had mixed experiences of communicating digitally – on the one hand, seeing that children can be very comfortable and adept at this form of communication, and on the other finding that it can be an inhibitor to children being able to freely express their wishes and feelings. A few advocates have encountered disabled children and children with mental health difficulties firmly choosing not to communicate by telephone or computer. Then there are children who are not permitted mobile telephones or Internet access for safeguarding reasons. We informed the Committee of advocates' concerns in relation to children's privacy:

    Social distancing measures and restrictions on movement have a particularly negative impact on privacy rights within institutional settings. Some advocates have expressed concerns about children's ability to speak freely, privately and confidentially to their advocate and there is a higher likelihood of children being controlled and prompted during their phone/video calls. In some cases, foster carers have complained about questions asked by advocates, including those that related to the child's experience of the foster placement and what contact they wanted with their family, and failed to facilitate children having private and confidential discussions where they have space to voice their wishes and feelings. In two cases, one of which concerned a children's home and another a foster placement, an advocate has had to raise the issue formally with the local authority.

79. Even before the 2020 Regulations came into force, advocates reported to us that local authorities were suspending their statutory complaints procedure. We informed the

[25] https://article39.org.uk/2020/04/20/unregulated-provision-consultation-will-be-fundamentally-flawed-without-meaningful-consultation-with-children-and-young-people/

Committee:

Between 27 March and 23 April, no changes had actually been made to the legal framework for the Children Act 1989 statutory complaints procedure. Yet, advocates saw some local authorities redrafting their complaints processes and switching to a 'prioritisation mode'. This confusion about statutory duties was not helped by Department for Education guidance issued at the time that incorrectly suggested local authorities could simply not comply with their statutory duties, providing they recorded the reasons for doing so. Article 39 co-drafted an open letter to the Children's Minister calling for the guidance to be clarified, which it subsequently was, but it is important to note the significant confusion amongst those working in children's social care regarding changes to law and regulations.

...

At Article 39 we have heard concerns about local changes to complaints mechanisms and procedures and received reports of great variation in practice, with some authorities accepting and investigating complaints as normal and others being reluctant to take on any new ones. Advocates have shared examples of authorities wrongly informing children and young people at Stage 1 that if they are unhappy about the outcome of their complaint that they need to make a complaint to the LGO – even though this has not exhausted the social care statutory procedure and referrals to the LGO are not currently possible. Children and young people's complaints are being handled under the corporate complaints procedure rather than the statutory social care procedure and there is a lack of impartiality in the statutory social care procedure itself.

Concerns have been raised about time-critical complaints and the impact of delays on children and young people's current as well as future circumstances - examples included a time-sensitive complaint relating to access to education in September 2020 and complaints regarding the age assessment of unaccompanied children in the asylum system where access to appropriate support is entirely dependent on the resolution of the age dispute. Timeframes are being missed without clear reasons being provided or an extension requested and there is a danger that Covid-19 is being used as a blanket excuse.

The Children Act 1989 complaints procedure should be seen as an opportunity to learn and improve the process, but systems currently suffer from a lack of oversight and quality assurance. If young people's concerns are not followed up, not even acknowledged in some cases, this can exacerbate existing feelings of worthlessness. It is also important to remember that the Children Act 1989 complaints procedure can prevent further damage being done by, for instance, ensuring that a decision to move a child in care is frozen whilst the complaint is being investigated.[26]

80. Since we submitted the above evidence to the Committee last month, we have received further information from advocates in three different parts of the country. Two advocates informed us of looked after children who have not been visited by their social worker within the statutory timescales (now diluted); another told us that disabled children have had their short breaks stopped; and one advocate told us that a child they advocate for was moved outside their home area and their statutory review held without the advocate being informed.

26 https://committees.parliament.uk/writtenevidence/7971/html/

81. On 10 June 2020, I facilitated an online consultation with 10 young adults who were formerly in care and placed in supported (unregulated) accommodation. A civil servant observed the 90-minute session and a detailed note of what the young people said was submitted to the Department as part of its consultation on unregulated accommodation. Young people have given Article 39 permission to publish the note of the meeting.

82. I have been listening to children in care and care leavers for the whole of my career, yet I found the young people's experiences to be shocking. One young man said he had been [the subject of a serious crime] by a member of staff (he advised: "Staff should have had more advanced DBS checks"), a young woman said she had been admitted to hospital with a lung infection on account of the mould in her property and others spoke of the accommodation being "basically borstal-type accommodation", "it feels like you are in prison" and "It's like a house without parents". One young woman explained:

    It's a survival system. You have to be like Bear Grylls – and survive – it's the only thing you know what to do. And then you're automatically penalised. If you're not naughty, you're overlooked. You don't have a Mum or Dad, they forget that.

Secretary of State's monitoring of the 2020 Regulations

83. The Defendant's detailed grounds state that Article 39 "has not placed any evidence before the Court of any child being adversely affected by the use of the flexibilities provided by the 2020 Regulations". We are a very small charity seeking to reinstate safeguards which have evolved over many decades and for which the government's own statutory guidance confirms are necessary. The Department must be aware of the history of large numbers of children in care having their needs unmet, and this often not being identified until many years later.

84. I am not aware of any new mechanism set up by the Department itself through which children, parents or their independent advocates can notify the Secretary of State (civil servants) of any harm they have suffered, or are at risk of suffering, as a consequence of the 2020 Regulations.

85. The Secretary of State is legally required to review the effectiveness of the regulatory changes … However, it seems only to record which regulatory changes local authorities have actioned, together with their latest inspection rating. I have not been able to find in any of the documentation details of how the Department itself is monitoring the impact on individual children of the regulatory changes. In this respect, it is of note that recent answers to Parliamentary Questions have elicited that the Department does not hold information on:
    a) The number of social workers who have been shielding or self-isolating[27]
    b) The number of children who have gone missing from care since the COVID-19 lockdown,[28] and
    c) The number of children who have been placed with fostering to adopt carers since the 2020 Regulations came into force.[29]

86. I would also urge caution in placing too much reliance on local authority feedback. During the 1990s I had successive roles advocating on behalf of children in care in local authorities. On both occasions the Directors of Social Services implored me to go directly

27 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-06-18/61514/

28 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-06-01/52029/

29 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-07-01/67715/

to them, and not to middle managers, with any concerns about how children were being treated in care.

87. Even taking into account the Department's apparent rudimentary monitoring, it is extremely concerning that, across the months of June and July, Exhibit SL17 shows there were a total of 114 "no response" references, presumably meaning that no information was elicited at that time about which of the regulatory changes were being implemented. Moreover, 24 local authorities – 16% of England's total – are listed as "no response" in both June and July.

Secretary of State's current position

88. [Name of civil servant] second witness statement explains that the Department's statutory review has concluded that the majority of the 2020 Regulations can expire on 25 September 2020:

    the Minister is planning to announce that she is minded to allow the vast majority of the regulations to lapse on 25 September but that there is a case for a small number of regulations to continue beyond 25 September.

89. [Name of civil servant] indicates three reasons for the Department choosing to keep the 2020 Regulations in force for another 10 weeks: that immediate revocation "would not however allow time for consultation or for the ordinary parliamentary processes to be followed, given the parliamentary summer recess"; that the House of Commons did not vote to annul the Regulations in June; and "that there is no evidence of the flexibilities being used where this is not justified for COVID-19 related reasons".

90. This was confirmed in a Written Ministerial Statement by the Children's Minister published on Parliament's website on the evening of 14 July 2020, in which she said:

    The extraordinary measures the Government has taken over the last few months means that we are now in a much better position to ease the restrictions that everyone has faced. Given the lower level of coronavirus now present, there is a significantly reduced need for local authorities and providers to use these flexibilities. I therefore intend to update guidance immediately to make it clear that there should no longer be a need to use most of these flexibilities and will be writing to local authorities and providers accordingly. Where they do use flexibilities, local authorities and providers should ensure that they have strong justification.[30] [Emphasis added]

91. On the need for public consultation and the parliamentary process, it would make no difference at all were the 2020 Regulations to be fully revoked and immediately replaced with a small number of carry-over changes[31] to 25 September 2020, which are genuinely necessary to safeguard and promote the welfare of children in response to COVID-19. As for the House of Commons not voting to annul the Regulations in June, this decision was of course taken before the Department's review had concluded. In respect of the third possible reason for delaying the re-establishment of children's legal protections, it is not clear to me how the Department can be confident that statutory duties in place before 24 April 2020 are not now being fulfilled due to COVID-19 (and its effects) alone.

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[30] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2020-07-14/HCWS368/

[31] The Minister identified three areas in her Written Statement – medical reports required for the fostering and adoption approval process; virtual visits during local lockdowns or when individuals are infected (or suspected of being infected); and the phased return of Ofsted inspections.

92. In response to the Minister's Written Statement, the Children's Commissioner for England has tweeted to say she is:

    … disappointed that the Government has not taken the opportunity to revoke these regulations as soon as possible, although I am pleased that the vast majority will be revoked in September. I maintain my view that these changes are not necessary, particularly as some of the fears around staffing levels in children's services have not materialised. At this time, when the pandemic means that children are less visible to statutory services, it is more important than ever that children's rights are protected.

93. I note [name of civil servant] reference to Barnardo's recent declaration of a 'state of emergency' "as the number of children needing foster care during the pandemic rises by 44%". The Full Fact charity examined Barnardo's claim, noting that:

    Newspapers reported this figure directly from a press release from children's charity Barnardo's, but it didn't have the evidence to back this up.

94. Barnardo's itself told Full Fact, "it would be fair to say that it's uncertain whether other fostering agencies have seen the same increase in referrals".

95. Full Fact concluded that the 44% claim was inaccurate:

    Barnardo's has seen a 44% rise in the number of referrals to its fostering services from councils in England, Wales and Northern Ireland. But that doesn't mean the number of children needing foster care has risen by 44%.

Concluding remarks

96. A recent feature article on the impact of lockdown on vulnerable children, living with their families and in the care system, reports the Children's Commissioner for England's continuing opposition to the 2020 Regulations. The Commissioner, Anne Longfield, told the journalist: "It can't be just about the functioning of that system; it has to be about the children within it".[32] This in essence sums up Article 39's claim. The safeguards we are defending were carefully crafted for vulnerable children who do not have their parents by their side. As I indicated in my first witness statement, many local authorities were already struggling to meet their statutory obligations before lockdown. Ofsted recently published its latest inspection data, which shows that half of local authorities continue to be rated as inadequate or as requiring improvement to be good (14% and 36% respectively).[33] The evidence I have brought together and set out above shows the terrible, sometimes catastrophic, consequences for children when legal protections are not fulfilled. In this regard, it is important to note that, until they are revoked, it will be to the statutory framework as radically reconfigured by the 2020 Regulations which courts will look when hearing a claim on behalf of any looked after child failed by their local authority, not the ecosystem of legal protections in place before 24 April 2020.

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32 Louise Tickle, 9 July 2020, 'Young lives in lockdown: https://members.tortoisemedia.com/2020/07/09/children-at-risk-the-reckoning-louise-tickle/content.html?utm_source=twitter&utm_medium=social&utm_campaign=louise-tickle&utm_content=9july2020

33 https://www.gov.uk/government/publications/childrens-social-care-data-in-england-2020/main-findings-childrens-social-care-in-england-2020#inspection-of-la-childrens-services

97. Children depend upon adults to protect them; and those in the care of the state have cause to rely upon the most robust safeguards we are able to give – to help them recover from the deprivations, abuse, trauma and neglect they have already endured in their young lives but also to guard them from systems and people who would do them further harm. The Department has now agreed to reinstate the vast majority of the legal protections lost overnight in April 2020. To postpone this for a further two months to fit around the summer recess would once again be putting the needs of government above the rights and welfare of vulnerable children. That, in my view, is intolerable.

Carolyne Willow
Article 39 Director
15 July 2020