Abuse in residential care institutions for disabled children and young people

Report for the Scottish Child Abuse Inquiry

Anita Franklin

Jo Greenaway

Alice Leyman

Manchester Metropolitan University

April 2026

Project team

Anita Franklin, Professor of Childhood Studies, Manchester Metropolitan University

Dr Jo Greenaway, Senior Research Associate, Manchester Metropolitan University

Dr Alice Leyman, Research Associate, Manchester Metropolitan University

Disclaimer

The views and findings expressed in this report are those of the authors and do not necessarily reflect those of the Inquiry.

Copyright information

Anita Franklin, Jo Greenaway, and Alice Leyman (2026). Abuse in residential care institutions for disabled children and young people. Report for the Scottish Child Abuse Inquiry.

Published by

Scottish Child Abuse Inquiry, Edinburgh.

Published date

April 2026

Contents

Glossary

ADHD – attention deficit hyperactivity disorder is a neurodevelopmental condition characterised by persistent patterns of inattention, hyperactivity, and impulsivity that can significantly impact daily life.

CDC – the Council for Disabled Children is part of the National Children’s Bureau family. The CDC is an umbrella body for the disabled children's sector with a membership of over 300 voluntary and community organisations and an active network of practitioners that spans education, health, and social care. As a membership body it provides a collective voice that champions the rights of children, young people, and their families and challenges barriers to inclusion.

Closed culture – the Care Quality Commission defines a closed culture as ‘a poor culture that can lead to harm, including human rights breaches such as abuse’ (CQC, 2022). In services with closed cultures, people are more likely to be at risk of deliberate or unintentional harm.

CQC – the Care Quality Commission is an independent body that monitors, inspects, and regulates health and social care services in England. In Scotland, this function is performed by the Care Inspectorate.

CSPR – a Child Safeguarding Practice Review is a systematic evaluation of serious cases of child abuse or neglect. These reviews aim to understand the circumstances surrounding the incident and identify any necessary changes to improve safeguarding practices.

DBS – the Disclosure and Barring Service is a non-departmental public body that provides information to employers in Engl Wales about a person’s criminal convictions and cautions to prevent the employment of unsuitable individuals. In Scotland this service is provided by Disclosure Scotland.

DoL – a deprivation of liberty order in England and Wales may include authorisation for children to be always supervised, prevented from leaving their accommodation at will, denied phone and internet access, and restrained by professionals – when this is deemed necessary for their own or others’ safety. DoL orders, as they exist in England and Wales, are not automatically recognised in Scotland. In Scotland, there is no direct equivalent to the DoL order for children, and children and young people can only be deprived of their liberty through statutory provisions, such as compulsory supervision orders, or through being placed in secure accommodation.

While the Scottish Government has implemented regulations to facilitate cross-border placements of children from other parts of the UK under DoL orders, these are not equivalent to DoL orders themselves.

DoLS – deprivation of liberty safeguards can be used to protect people who cannot consent to their care arrangements and are deprived of their liberty. DoLS were introduced as an amendment to the Mental Capacity Act 2005 and apply to England and Wales only.

ICR – an initial case review is a rapid review conducted when a child dies or is seriously harmed due to suspected abuse or neglect. These reviews aim to quickly identify immediate learning to improve safeguarding practices and prevent similar incidents in the future.

IRO – an Independent Reviewing Officer is a qualified social worker responsible for ensuring the quality of care planning for children in care. IROs chair review meetings, monitor progress, and advocate for the child's best interests, ensuring their wishes and feelings are considered.

LADO – Local Authority Designated Officer. Within England there are statutory duties placed upon local authorities within which a residential setting is based, including the requirement to have a LADO who is responsible for the oversight of child protection allegations made against staff and volunteers who work with children and young people (DfE, 2023). Scotland has specific national guidance covering all aspects of child protection in Scotland (Scottish Government, 2023).

Learning review – in Scotland, a learning review is a multi-agency process for reviewing cases where a child has experienced significant harm or is at risk of it, or where an adult has died under specific circumstances, to identify areas for improvement in child protection and adult support and protection systems.

NSPCC – the National Society for the Prevention of Cruelty to Children is a British child protection charity. The NSPCC lobbies the government on issues relating to child welfare and creates child abuse public awareness campaigns. Since the 1980s the charity has had statutory powers, allowing it to apply for help on behalf of children at risk.

OCD – obsessive compulsive disorder is a mental health condition characterised by recurring unwanted thoughts (obsessions) and repetitive behaviours or mental acts (compulsions) performed in response to those thoughts. These obsessions and compulsions can be distressing and significantly interfere with daily life.

SEND – special educational needs and disabilities are learning difficulties or disabilities in children that require them to have special educational or health support. This includes a wide range of needs, from learning disabilities such as dyslexia to physical or sensory impairments, and needs relating to autism or ADHD. The term is predominantly used in England.

SCR – in England, a serious case review was an in-depth investigation conducted when a child died or suffered serious harm due to abuse or neglect, or when there were concerns about how agencies worked together to protect a child. Its purpose was to identify lessons learned and improve child protection practices to prevent future tragedies. SCRs are now called child safeguarding practice reviews (CSPRs) in England. The term changed following reforms introduced by the Children and Social Work Act 2017, which came into effect in 2019.

SLT – speech and language therapy provides treatment, support, and care for children and adults who have difficulties with communication, eating, drinking, and swallowing.

SSCR – in Scotland, a significant case review was conducted when a child died or was significantly harmed, and there were concerns about the involvement of agencies or services. The primary goal was to identify lessons and improve child protection practices. The National Guidance for Child Protection Committees (2021, updated 2024) renamed these ‘learning reviews’.

UNCRC – the United Nations Convention on the Rights of the Child is a legally binding international agreement that outlines the fundamental human rights of children. It covers civil, political, economic, social, and cultural rights, ensuring every child, regardless of background, is afforded these rights.

UNCRPD – the United Nations Convention on the Rights of Persons with Disabilities is an international treaty that aims to protect and promote the human rights and fundamental freedoms of disabled people worldwide.

UNICEF – the United Nations International Children’s Emergency Fund is a United Nations agency that provides humanitarian and developmental aid to children worldwide.

Introduction

This review of UK and international evidence on the abuse of disabled children and young people[1] in residential care institutions was commissioned by the Scottish Child Abuse Inquiry (SCAI) and forms part of its wider investigations into the abuse of children in care in Scotland.

The statutory Scottish Child Abuse Inquiry (SCAI, or the Inquiry) was established in October 2015 under the Inquiries Act 2005. Its remit is wide-ranging, and includes the following:

- to investigate the nature and extent of abuse of children whilst in care in Scotland, during the relevant inquiry time frame
- to consider the extent to which institutions and bodies with legal responsibility for the care of children failed in their duty to protect children in care in Scotland (or children whose care was arranged in Scotland) from abuse, regardless of where that abuse occurred, and in particular to identify any systemic failures in fulfilling that duty
- to create a national public record and commentary on abuse of children in care in Scotland during the relevant time frame
- to examine how abuse affected and still affects victims in the long term, and how in turn it affects their families
- to consider the extent to which failures by state or non-state institutions (including the courts) to protect children in care in Scotland from abuse have been addressed by changes to practice, policy, or legislation
- to consider whether further changes in practice, policy, or legislation are necessary to protect children in care in Scotland from such abuse in future.

The overall aim of the Inquiry is to raise public awareness of the abuse of children in care, and to provide an opportunity for public acknowledgement and a forum for the validation of individuals' experiences and testimony. The Inquiry has investigated the abuse of children in care in a variety of settings. Beginning in April 2025, Phase 9 of SCAI's investigations concerns the provision of residential care in establishments for

---

1 The term 'disabled children' is used widely within the UK, and within this report, because it is consistent with the social model of disability (Oliver, 1996), whereby children are disabled by society or the environment. 'Children with disabilities' is an alternative term and more widely used internationally; however, while person- and child-centred, this term implies that the disability is something intrinsic to the child.

For the purposes of this review 'children' includes children and young people up to the age of 18.

children and young people with long-term healthcare needs, additional support needs, and disabilities. The overall aim of this report is to review the available evidence in relation to the abuse of disabled children up to the age of 18 (including those with long-term health needs and additional support needs) in residential care settings. Few studies have investigated the abuse of disabled children in residential care in Scotland; evidence is therefore included from across the UK and internationally in order to share wider learning which has relevance.

In order to explore these issues in depth, the report is structured into three parts, each addressing a different aspect of the review process and findings.

- Part 1 sets out the context of abuses of disabled children and of institutional settings for disabled children.
- Part 2 explains the scope and parameters of the review and the systematic methods used to identify relevant publications and assess their quality.
- Part 3 presents the findings of the review guided by the specified research questions.

We end the report by drawing together the evidence to present what is known, and to provide some concluding statements to draw attention to the need for urgent policy and practice change.

Part 1 – Context

The number of disabled children living in institutional settings worldwide is not known, largely due to inconsistent definitions of disability and of setting type, and significant gaps in robust and systematic data collection and reporting. Many disabled children's needs will be undiagnosed and unrecognised in residential settings, and therefore their disability status will not be recorded. There are also multiple definitional challenges regarding the nature of residential settings as well as significant challenges with missing data.[2] These issues with definitions and recognition of disability present problems with regard to accurate numbers being established.

There is also little data on the context of abuse of disabled children in residential care worldwide, including within Scotland. This research concerns the intersection of abuse of disabled children in residential settings. Therefore, to understand the context of this intersection, the following sections consider these three factors (children, disability, and residential settings) with reference to the situation within Scotland as well as further afield.

Child abuse in Scotland

Child abuse remains a significant concern in Scotland. The latest child protection statistics published by the Scottish Government (2025) indicate that 'on 31 July 2024, 2,129 children were on the child protection register, representing a 3% increase on 2023 (2,077) and a 26% decrease on 2014 (2,877)'. Children are placed on the register for a variety of reasons including domestic abuse (45% of children registered), neglect (42% of children registered), parental substance use (39% of children registered), parental mental ill health (37% of children registered), and emotional abuse (33% of children registered).

Despite these figures, Scotland lacks comprehensive studies that explore the prevalence and patterns of abuse specifically affecting disabled children. Much of what is known comes from case review data and reports from regulatory bodies. In Scotland the death of a child, or serious harm caused to a child, is subject to review for responsible agencies to learn and improve practice. These reviews provide some data and understanding of concerns. Between 2012 and 2022 local child protection committees in Scotland were responsible for carrying out initial case reviews (ICRs) or (Scottish) significant case reviews (SSCRs) whenever a child had died or had been

---

[2] See, for example, Ofsted (2024a).

significantly harmed. These reviews offer some insight into the system's response to serious incidents, although they do not capture the full picture of the prevalence of abuse.

In 2021 the Care Inspectorate published a triennial review of ICRs and SSCRs carried out between 1 April 2018 and 31 March 2021 (Care Inspectorate, 2021). Most of the children who were the subject of an ICR or SSCR were living at home at the time of the incident (80% and 91% respectively). Of the children who were the subject of an SSCR (n=32), six were recorded as having a disability, possible disability was recorded in one case (autism), and in seven cases it was confirmed that the child did not have a disability. Disability status was not provided for 18 children. Of the children who were the subject of an ICR, seven were recorded as having a disability, eight were recorded as not having a disability, and the disability status of the remaining 50 children was not recorded. Eight children who were the subject of an ICR and three children who were the subject of a SSCR were looked after and accommodated.

Since 2021 the updated *National Guidance for Child Protection Committees Undertaking Learning Reviews* (Scottish Government, 2024) renamed ICRs and SSCRs as 'learning reviews'. Learning reviews continue to be the responsibility of local child protection committees. In 2023 the Care Inspectorate published its first annual summary of learning reviews (Care Inspectorate, 2023a). The 14 learning review notifications received by the Care Inspectorate concerned 20 children, none of whom were recorded as disabled. In 2024 the Care Inspectorate reported that 50 learning review notifications concerning 79 children had been received in 2023/24 (Care Inspectorate, 2024a). Of the 50 notifications, 23 proceeded to a learning review concerning 49 children, including seven disabled children. From the little information gleaned from the statistical data, it is not possible to determine whether the harm of a disabled child was as a result of abuse within residential care or in other care settings such as foster or kinship care.

Abuse of children in care

A research review commissioned by SCAI examined the nature and extent of abuse of children in care in Scotland. The review considered 61 studies from across the globe, but it did not specifically focus on the abuse of disabled children, although it highlighted evidence of increased risks for this group (Radford *et al.*, 2017). The review emphasised issues concerning the accuracy and prevalence of historical records of abuse in the care system, and the lack of Scottish-specific data of self-reported abuse. However, it should be noted that challenges of accessibility for disabled children, and of disabled adult survivors, to self-report abuse may present an under-reporting by this group, and thus skew data.

The SCAI review (Radford *et al.*, 2017) drew upon Biehal and colleagues' study (2014), which collected data from 156 local authorities in England, Wales, Northern Ireland, and Scotland of physical, sexual, and emotional abuse and neglect in residential care over a three-year period (2009–12) and extrapolated to create estimates for the whole of the UK. The study found lower rates of allegations and confirmed abuses in care settings in Scotland than in England and Wales for all children. It is unclear whether this reflects real differences in rates of abuse or if differences in the thresholds applied of what is recorded in the different nations. The analysis did not disaggregate estimates for disabled children, although this group of children is over-represented within residential settings (McConkey *et al.*, 2012; McTier, 2024).

Abuse of disabled children and young people

There are challenges around definitions of disability and significant variation in how data on disability and additional support needs is collected across Scotland's children's social work statistics (McTier, 2024). Further corroboration of these challenges was provided by Scotland's Care Inspectorate's thematic review on disabled children and young people's experiences of social work services, which reported that there is no reliable data nor a shared definition of disability. The review also highlighted the impact of limited data, which hinders planning, delivery, and budgeting (Care Inspectorate, 2024b).

Despite the challenges around defining and recording disability, evidence from across the world highlights that disabled children are at increased risk of harm and abuse compared with non-disabled children (Cappa *et al.*, 2015; Stalker and McArthur, 2012; Jones *et al.*, 2012; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; Loeb *et al.*, 2002; Sullivan and Knutson, 2000; Franklin *et al.*, 2020, 2022; IICSA, 2022). The Independent Inquiry into Child Sexual Abuse (IICSA) in England and Wales (2015–22) highlighted that disabled children are at a heightened risk of being sexually exploited, and a common theme identified across the institutions it examined was that disabled children were often deliberately targeted. Significantly, those who had communication difficulties reported that they tried to tell someone that they were being sexually abused but their disclosure was not understood or was dismissed; some considered whether this dismissal was due to their being disabled (IICSA, 2022: 58). When considering multiple forms of abuse, the proportion of Truth Project participants taking part in the Inquiry who reported other forms of abuse and neglect was higher amongst those who reported a disability (59%) (IICSA, 2022: 30).[3]

Fang and colleagues (2022) provide the latest and most comprehensive review. Their global analysis showed that disabled children are twice as likely to experience violence[4] as their non-disabled peers. They found that the prevalence of violence was higher among children with ‘mental disorders’ (34%), or cognitive or learning disability (33%). Rates were lower among children with sensory impairments (27%), physical or mobility limitations (26%), or chronic diseases (21%). Prevalence also differed by the types of violence experienced: 32% for physical violence, 36% for emotional violence, 11% for sexual violence, and 19% for neglect. The authors, however, conclude that inconsistent definitions and measures of violence and of disability undermine the ability to compare studies. Despite such limitations, these studies are important in drawing attention to the increased risks of abuse of disabled children and young people. However, they do not reference the setting in which the abuse occurred and offer limited evidence regarding abuse of disabled children within institutional settings.

McTier (2024) summarised that without good-quality information about disabled children then there is a lack of awareness and visibility of this group and of their needs and experiences. This is significant, especially when concerning disabled children in residential settings where limited oversight and isolation can exacerbate the invisibility of disabled children and increase risk within the structures meant to support and protect them.

Disabled children and young people living away from home

Like any child, some disabled children require care and protection and to be supported by child protection processes, and may be placed in residential care if their parents are unable to provide the care they need. There is a vast array of settings, which can include residential schools, care homes, or other specialised facilities, and these are often initiated when a child's needs cannot be adequately met at home or in mainstream provision. However, not all disabled children in residential care in Scotland and the UK are considered ‘looked after’. Within Scotland and the rest of the UK, disabled children can enter residential settings through a

---

[3] The Truth Project was a core part of the Independent Inquiry into Child Sexual Abuse. It provided victims and survivors of child sexual abuse in England and Wales with the opportunity to share their experiences in ways they felt comfortable with. These testimonies informed IICSA’s work and recommendations.

[4] Within this study, ‘violence’ was defined as physical, emotional, or sexual violence and neglect.

combination of assessments, legal frameworks, and support services. While many disabled children in residential care are looked after by the local authority, others may be in residential care through private arrangements or under other legal frameworks within education and/or health provision, without a formal 'looked after' status, and thus still within the care of their families. This creates a complex picture, with disabled children within the residential estate not subject to the same levels of external scrutiny and monitoring by local authorities, which can impact on their protection and visibility.

In Scotland, children may become 'looked after' under the Children (Scotland) Act 1995. The Children's Social Work Statistics for 2023/24 reported that, of all the 11,844 children looked after on 31 July 2024, 10% were recorded as disabled (Scottish Government, 2025). However, the disability status of 25% of looked-after children was not known or recorded. Further analysis of the Children's Social Work Statistics for 2022/23 indicate that disabled children in Scotland who are looked after are less likely to be resident at home (6.6% compared to 20.9% of all looked-after children) but more likely to be looked after in residential care (26% compared to 10.2% for all looked-after children) (McTier, 2024). This correlates with the findings of McConkey and colleagues' (2014) study in Ireland, which found children with intellectual disabilities[5] were 12 times more likely to be in care compared to non-disabled children, while those with more complex needs were more likely to be placed in a residential setting rather than foster care. McConkey and colleagues (2014) report that difficulties in recruitment of foster carers for children with additional needs, a reluctance of social workers to risk failure in placements, and birth parents' reluctance to have their child fostered are potential reasons for this disparity. They highlight the need for development of more fostering options. Also of significance in this study is data highlighting that only small numbers of disabled children return to their birth families, are adopted, or enter foster care from residential settings. This indicates that disabled children were most likely to remain in residential care and that this often extended into adulthood (McConkey *et al.*, 2014). Similarly, within publications from the Aotearoa New Zealand Royal Commission of Inquiry (2024a), institutions such as the Kimberley Centre for people with learning disabilities were seen as a 'home for life', despite some children being admitted at a very young age.

According to a report by Lenehan and Geraghty (2017), which reviewed the experiences of children and young people with special educational needs and

---

[5] 'Intellectual disabilities' is the term used within the paper, and one that is more widely used internationally. Predominantly within the UK the term 'learning disabilities' is used.

disabilities (SEND) in residential special schools and colleges in England, there were 4,878 children boarding in residential special schools, and a further 1,268 boarding in specialist post-16 institutions: a total of 6,146 at that time, although how many of these children were 'looked after' is not known. More recently a report by Ofsted (2024) provided information with regard to residential care specifically for children with complex needs in England during 2022–3, stating that there were

- 590 children in residential special schools and residential special schools registered as children's homes
- 670 children living in children's homes who were subject to deprivation of liberty (DoL) orders
- around 50 children waiting for places in secure homes
- 915 placed in unregistered homes.

In addition, there were small numbers of children who were residing in hospital paediatric wards because they had nowhere to be discharged to. Reflecting only on these two reports (Ofsted, 2024; Lenehan and Geraghty, 2017), the way in which the groups of disabled children are defined and the differences in terminology used can cause confusion when interpreting the statistical information.

Eleven children and young people subject to DoL orders in England and Wales in January 2022 were placed in Scotland (Care Inspectorate, 2022b). Five of these children were recorded as having a formal diagnosis of autism. However, no further analysis of this group's specific circumstances was discussed. As will be explored in our findings, placing children far from home and, in this context, a different country with different child protection arrangements presents significant challenges in providing a safeguarding and monitoring framework to ensure a child's protection.

Abuse of disabled children living in institutions

The United Nations notes that disabled children in institutions are at an especially heightened risk of violence, abuse, and exploitation. In the report, the independent expert leading the United Nations global study on children deprived of liberty stated: 'Children with disabilities deprived of liberty are at a heightened risk of violence, abuse and exploitation, which may amount to torture or other forms of ill-treatment, including being restrained, shackled, secluded and/or beaten by staff as a form of control and/or punishment' (United Nations General Assembly, 2019: 9).

While disabled children face higher levels of abuse and are over-represented in institutional care, little research and policy attention has been given to this specific group of children.

When highlighting the gap in the focus on abuse of disabled children in residential settings, it is important to remember the devastating outcomes of child abuse in long-term care. A systematic review undertaken by Carr and colleagues (2017) for SCAI found significant associations between the experiences of child abuse in long-term care and adjustment across the life span in the domains of mental health, physical health, and psychosocial adjustment. They call for evidence-based, trauma-focused treatment for child abuse survivors, and to this we would add trauma recovery that is accessible to disabled child abuse survivors.

Disabled children's rights

Disabled children around the world have the same human rights as all other children. The United Nations Convention on the Rights of the Child (UNCRC) was ratified by the UK in 1991 and incorporated into domestic law in Scotland in 2024 when the UNCRC (Incorporation) (Scotland) Act 2024 came into force on 16 July 2024. The UNCRC outlines children's rights to protection, participation, and provision, which are interlinked, interdependent, and indivisible. Article 23 states that the realisation of disabled children's rights should ultimately lead to enjoyment of full and decent lives, with maximum inclusion in society.

In addition, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), adopted in 2006 and ratified by the UK in 2009, applies to all age groups. It specifically recognises that disabled children should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children. Article 23 states that disabled children have equal rights with respect to family life, that they should not be separated from their parents against their best interests, and never on grounds of disability. If alternative care is necessary, every effort should be made to provide it within the wider family, or within the community in a family setting. Both Conventions call on states to collect appropriate information and data to support the implementation of children's and disabled people's rights – including those of disabled children. The United Nations also highlights the need for disaggregated data to enable discrimination or potential discrimination of disabled children to be identified (OHCHR, 2018). This is imperative if we are to understand and address abuses of disabled children in residential institutional settings.

It is also important to acknowledge the long and ongoing activism of the disability rights movement to eliminate the institutionalisation of disabled people and the enactment of their right to independent living. Disabled people have a long and painful history of being placed in institutions purely because of being disabled, and this continues today. Debate concerning the institutionalisation of disabled children in residential settings is beyond the scope of this report. However, we do recognise disabled children's rights to family life and states' obligations to take appropriate measures to ensure the equal treatment and non-discrimination of disabled children under the UNCRC.

In summary, whilst disabled children and young people have the same rights to protection as all children, they are known to be at increased risk of abuse and are more likely to enter institutional care. However, little attention has been given to the intersection of abuse of disabled children and young people within residential settings. The complexity of and challenges to defining, describing, and understanding the nature and extent of disabled children currently living in residential settings is further explored in the findings. Definitional issues concerning disability, and the fact that some disabled children in residential settings are placed by their families whilst others are in state care, leads to an array of complex legal definitions and responsibilities. Despite the vast range of settings and situational contexts, the varying needs and experiences of disabled children are often united by poor experiences and increased risks to their safety, as the findings of this report will illustrate.

Part 2 – Scope and parameters of the review

The following sections set out the parameters of the review and outline the definitions used. We also reflect on the quality and quantity of the available evidence.

Research questions

To inform Phase 9 investigations, SCAI requested a review of evidence to answer the following research questions:

- What is known about the nature and extent of abuse of disabled children in residential care settings?
- What are the risk factors, and how may these differ for this group of children?
- What are the protective factors, and how may these differ for this group of children?
- How can abuse be prevented?
- What are the gaps in knowledge and understanding, and how could these potentially be addressed?

Parameters and definitions used within the review

It is important to provide clarification of the definitions and parameters used within this study, given the definitional challenges concerning disability and residential settings. Many of the definitions used within this review were aligned with SCAI's Terms of Reference.

Abuse

Abuse refers to all forms of physical, sexual, psychological, and emotional abuse. Given the specific context of disability provision, this review includes other forms of abuse, including medical experimentation, spiritual abuse, restrictive practices to incorporate harms caused by physical, chemical, and mechanical restraint, and forms of seclusion and deprivation of contact with family members.

Disabled

We use the definition of disability as it appears in the Equality Act 2010, as this consolidates UK discrimination law. Under this Act, a person is considered disabled if they have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on their ability to do normal daily activities.

Within this report, we adopt a social model definition of disability that highlights the disabling effects of structural, social, and attitudinal barriers on disabled children’s lives as separate from the individual experiences of, for example, physical or sensory impairments (Brady and Franklin, 2023).

Perpetrator of abuse

The review includes all perpetrators of abuse within residential settings, including children who abuse other children.[6]

Residential settings

The residential setting must be a specialist institution designated for disabled children or children who have additional health or support needs, and where the child has been placed in the institution predominantly on the basis of being disabled or requiring additional, associated support. This includes institutional residential care such as children’s homes (including residential care provided by faith-based groups); state, private, and independent boarding and residential schools; healthcare establishments providing long-term care; and any similar establishments intended to provide disabled children and young people with long-term residential care. It does not include short-term placements such as short breaks/respite care; schools (public or private) that do not have boarding or residential facilities; foster care; or kinship care.

Whilst the focus of this review is on specialist institutions designated for disabled children, we want to draw attention to and acknowledge the large numbers of disabled children and children with additional support needs who are placed in other forms of ‘non-specialist disability’ provision, and whose needs may not have been diagnosed, assessed, understood, and met within these settings. Hart and LaValle (2016), for example, pointed to the many disabled children in settings, including within secure children’s homes, with mental health and trauma-related needs who do not receive the support they require. The unmet and/or unrecognised needs of children and young people with special educational needs in secure settings has also

---

[6] The term ‘peer-on-peer abuse’ is widely used; however, it is problematic. SCAI prefers ‘children abused by other children’ or ‘children who engaged in abusive behaviour’. For consistency, we use the terms used by the authors themselves when citing from the literature, and we use SCAI’s preferred terms within wider discussion of this form of abuse.

been highlighted by the Children’s Commissioner for England (2025). McTier (2024) noted high levels of disability-related needs across all care settings in his analysis of disabled children’s statistical data reported across Scotland’s children’s services. Whilst difficulties in the identification of this particular cohort of children resulted in their experiences not being included in this review, the abuses of disabled children in these settings must not be forgotten or hidden. Nuanced and intersectional understanding of these abuses, and of identification, response, and recovery in these settings is also required within further reviews and research.

Scope of review

The final review protocol and timeline was discussed and agreed with the SCAI team to ensure fitness for purpose and to align with the start of Phase 9 hearings.

Evidence was reviewed from the following sources:

- Academic peer-reviewed journal articles from the UK and, internationally, from Canada, Australia, New Zealand, and Northern Europe (to align with broadly similar cultural contexts)
- A sample of up to 20 relevant initial case reviews (ICRs), significant case reviews (SSCRs), learning reviews, serious case reviews (SCRs), practice reviews, independent reviews, or inquiry reports across the UK[7]
- Relevant international inquiries and commissions within countries aligned to a cultural context similar to that of the UK.

In addition, grey literature (reports from government or voluntary sector organisations) from the UK and internationally was sourced from relevant websites. This has been utilised to inform the background of the review and to aid understanding of context. However, for the purposes of this review, focus is placed on evidence that has been through some level of independent scrutiny to ensure a measurable level of quality to the data.

Inclusion criteria

- Papers and reports published in English, including international studies from Northern Europe, USA, Canada, Australia, and New Zealand

---

[7] The NSPCC provides an overview of the different case review processes across the UK (NSPCC Learning, 2026).

- Papers and reports published since 2014[8]
- Papers and reports relating to disabled children and young people up to the age of 18.

In addition, research studies were assessed against a broad set of pre-defined quality criteria based on the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (2024).[9]

Before reporting on the key findings in relation to the research questions posed, we first reflect on the quantity and quality of the evidence available. This is important for assessing the reliability and validity of the review's findings, and to understand the strength of evidence that underpins the conclusions drawn.

Quantity and quality of data

Overall, the review found a paucity of research evidence examining the abuse of disabled children in institutions. The following presents a short overview of the data that forms the basis of this review.

Peer-reviewed journal articles

Of the 68 peer-reviewed journal articles published during the search period (2014 to 2024) and selected for full extraction, only three fully met the criteria for inclusion (Euser *et al.*, 2016; Wissink *et al.*, 2017; Hoffmann *et al.*, 2020). The fact that only three articles fully met the agreed criteria indicates a severe lack of attention to this group of children within academic research. The evidence from these three articles is highlighted in the findings section, supported by the journal articles that partially met the inclusion criteria, as well as case reviews and grey material.

The remaining 65 articles did not meet the full inclusion criteria because

- they did not explicitly refer to abuse within residential care
- the findings did not specifically concern disabled children in residential settings, or disabled children could not be disaggregated from other data

---

[8] Literature from outside this date range has been included when it provides specific relevance and addresses gaps in more recent evidence.
[9] See *Appendix C*.

- they covered more general issues such as training and ‘safe restraint’ rather than abuse of disabled children within residential settings.

Of the articles that did not meet the full inclusion criteria, it should be noted that only eight were Scottish-focused. Table 1 details why they did not meet the full inclusion criteria.

Table 1: Summary of Scottish journal articles and reasons for exclusion

Journal article	Meeting the inclusion criteria			Focus of article
	Disabled children	Abuse	Residential care	
Harris and Riddell (2022)	Y			Rights of disabled children within Scotland in the context of education services, not residential nor abuse
Johnson *et al.* (2017)			Y	Self-harm and residential staff responses
Nixon and Henderson (2022)			Y	Traumatic early experiences and therapeutic response
Riddell *et al.* (2021)	Y			Rights of disabled children within Scotland in the context of education services, not residential nor abuse
Riddell and Carmichael (2019)	Y			Rights of disabled children within Scotland in the context of education services, not residential nor abuse
Smith and Carroll (2015)	Y		Y	Best practice and inter-professional working between child residential care and mental health staff within Scotland and five other European countries
Stalker *et al.* (2015)	Y	Y		Child protection awareness and response of practitioners. No specific focus on residential care, nor on harms within care
Steckley (2017)			Y	Physical restriction and restraint in residential care

In addition to the above eight journal articles, a further seven are drawn upon. Two of these (Franklin and Goff, 2018; Robinson and Graham, 2021) highlight the experiences of disabled children and young people themselves and suggest how practice within residential settings can be improved. The other five articles are examined as these focused on restraint and seclusion (Calabrese *et al.*, 2024; Caldwell *et al.*, 2014; Nunno *et al.*, 2022; O’Donoghue *et al.*, 2020; Green-Hennessy and Hennessy, 2015). The issue of restraint and seclusion is important to examine given the potential for these practices to be abusive if not utilised in appropriate ways and as a last resort to prevent harm. We have therefore referred to these articles alongside findings of grey literature, inquiries, SSCRs, and SCRs that have highlighted the problematic and abusive use of restraint.

Individual case reviews

Searches of the Care Inspectorate's and local child protection committees' websites identified executive summaries of one SCR ('Isabelle') and one learning review ('YP D') concerning disabled children who had been accommodated in residential care in Scotland. 'Isabelle' (Angus Child Protection Committee, 2020) had been accommodated in residential care and met the age criterion. 'YP D' (City of Edinburgh Child Protection Committee, 2024) was known to social services from an early age and was looked after and accommodated in secure care when aged 13. It is unclear how long this young person was accommodated for, and the learning review focuses on the period when they became homeless at the age of 16. Whilst this review does not fully meet the inclusion criteria, it corroborates the findings from other reviews regarding meeting the needs of neurodivergent young people and thus offers further learning which is included below.

Searches of the NSPCC repository identified nine SCRs or safeguarding practice reviews concerning individual disabled children's experiences of abuse whilst in residential care. An additional report for 'Beth' (SIIR, 2019) was known to the reviewers and located within the UK government website. These reviews and the report were conducted by English local authorities and were of individual cases of serious abuse or death of a disabled child.[10]

Group settings reviews

The Review of the Hesley Group in England (Child Safeguarding Practice Review Panel, 2022, 2023 (henceforth the Hesley Review)) and the investigations carried out by the Independent Inquiry into Child Sexual Abuse (IICSA) in England and Wales (IICSA, 2022) reviewed harms within group settings and are nationally significant. There is an overemphasis on the learning from these given the depth of examination of the issues and the limited other sources from which to draw.

The Hesley Review (2022, 2023) provided a comprehensive examination of the experiences of 108 children placed at the three independent specialist residential

---

[10] Further details of these reviews and report are provided in Appendix B.

settings operated by the Hesley Group in Doncaster: Fullerton House, Wilsic Hall, and Wheatley House. The review aimed to understand how disabled children continue to be failed by the care system that should be caring for and protecting them. The first phase of the review examined what went wrong and why. The second detailed critical issues regarding the adequacy of provision and made recommendations to prevent such abuses happening again. The Hesley Review provides our most comprehensive recent evidence of how abuse was allowed to occur and what needs to change in residential settings, albeit the data is limited and drawn from one private residential provider in England.

The IICSA was a statutory inquiry for England and Wales, established in 2015 under the Inquiries Act 2005. Its remit was wide-ranging, and it highlighted the abuses of disabled children across a range of settings. It published its final report in 2022, with a long list of recommendations for improvements in how institutions must protect children (IICSA, 2022).

Other inquiries

Internationally we draw upon evidence gathered as part of the Royal Commission of Inquiry into Abuse in Care in Aotearoa New Zealand (Royal Commission of Inquiry, 2024b; Mirfin-Veitch and Conder, 2017; Mirfin-Veitch *et al.*, 2022). This evidence is important as, unlike most evidence available,

- it draws upon the narratives of disabled people themselves of their lived experience of a childhood in residential settings
- it is disaggregated from the stories of other adults recalling their experiences in foster care or who were not disabled
- it provides details of how disabled children in New Zealand disproportionately entered care and disproportionately experienced abuse and neglect in contrast to non-disabled children
- it has a specific focus on disability and, importantly, D/deaf children
- it highlights intersectional needs and identities of disabled children
- it highlights disablism and audism as creating pathways for D/deaf and Disabled children to enter care.

Grey literature

An extensive search of grey literature (non-peer-reviewed material) identified over 60 reports that appeared to meet the inclusion criteria. Many reports had to be excluded due to one or more of a range of factors:

- The samples were often adults who had experienced institutional care a long time ago.
- The reports were not specifically focused on disability.
- There were no references to abuse in residential settings.
- Out-of-home care such as foster care was discussed generally.
- Relevant information related to residential settings could not be clearly disaggregated.

Thus, the final inclusion list was reduced to six Scottish and 10 international reports.

In summary, the evidence base from which to answer the research questions is very limited, although material does evidence patterns of abuse and failures across the UK and international context. The full nature and extent of abuse of disabled children and young people is difficult to determine, especially as abuse within residential settings by staff may be known about but not necessarily reported. It may also not be subject to a review or government report that is made publicly available. In addition, it is known that children will often not report their abuse due to a wide number of barriers (Allnock and Miller, 2013; IICSA, 2019), and disabled children in particular face further additional barriers to disclosure or discovery of their abuse (Jones *et al.*, 2017).

However, it is very important to note that there are multiple known cases of abuses within residential settings for disabled children where concerns had been raised across the UK, including within Scotland.[11] A brief search of newspaper articles and

---

[11] See, for example, Disclosure, Disclosure – Kids on the psychiatric ward, BBC1 Scotland (10 February 2025); The Newsroom, *Lothian schools for disabled kids investigated by abuse inquiry*, *Edinburgh Evening News* (13 September 2018); Michael McEwan, *The shameful legacy of the Lennox Castle hospital*, BBC News (7 January 2022); Cheryl Peebles, *Five men accused of abusing 42 children at Fife special school across more than three decades*, *The Courier* (17 July 2019); Victoria MacDonald, Boy with profound learning disabilities reaches out of court settlement after abuse in residential school,

journalistic exposés shows a long, painful, and very recent history of abuse, yet we were unable to find official documentation, reports, or investigations through publicly available sources. This may be due to time delays in terms of length of investigations and/or possible criminal proceedings and subsequent publication. However, there appears to be a lack of transparency, accessibility, coordination, and accountability across the UK from which to gain a sense of the scale and nature of abuse and learning that would support prevention and improve responses and recovery. This directly links to the challenges already highlighted concerning the lack of data on disabled children, agreed definitions for disability, and, we would argue, a lack of investment in funding this important work. This has considerable implications for prevention, identification, responses, and recovery which are explored further in the findings. This also has significant implications in terms of access to justice for disabled children and their families and leads to a lack of impetus for change at national policy and practice levels.

Channel 4 News (15 May 2024); Noel Titheradge, *'Abuse, assaults and big profits' – children's homes staff speak out*, BBC News (9 June 2022)

Part 3 – Findings

In the following sections we have drawn together the evidence that is currently available to address each research question.

What is known about the nature and extent of abuse of disabled children in residential care settings?

The challenges to understanding the prevalence and nature of the abuse of disabled children caused by the lack of a consistent definition of disability are well-established, as is the lack of uniform methods of classifying abuse. UNICEF's (2024) analysis of the prevalence of disabled children in care compared with non-disabled children details the difficulties in establishing data from specific alternative care arrangements. It argues that comparing any prevalence of children in residential care with those in other forms of care is complicated by different definitions. McTier (2024) succinctly highlights in his comprehensive report the challenges of all forms of data collection on disabled children and analysis within the Scottish context.

Prevalence and extent of abuse

The three journal articles that fully met the inclusion criteria provide some, albeit limited, evidence on the extent of abuse. Euser and colleagues' (2016) study examined the prevalence of sexual abuse of children with mild intellectual disability in foster and residential care in the Netherlands. The data set consists of reports of child sexual abuse made by 104 randomly selected professionals who worked with children in all forms of out-of-home care (residential and foster care). The data, which was disaggregated for types of residential care, suggests that as many as 11.5 per 1000 children with an intellectual disability in specialist residential care were subject to child sexual abuse compared with 3.5 per 1000 children in regular out-of-home care, and 0.8 per 1000 children in the general population of the Netherlands, thus indicating increased risks of sexual abuse within residential care.

Wissink and colleagues (2017) examined evidence from case files (n=128) submitted to the Inspectorate of Health and the Inspectorate of Youth Care in the Netherlands over a three-year period (2008–10). The data examines the prevalence of child sexual abuse within care, comparing those with and without intellectual disability. Wissink and colleagues found that in 85 per cent of reported cases (n=109) the incidence of sexual abuse concerned a child with intellectual disability who was placed in residential care. Nearly half of all cases of abuse (n=63, 49%) were suspected as being a result of 'group mate or peer abuse'.

Both studies focused on intellectual disability and sexual abuse and have limitations in terms of data collection being based on staff reporting of abuses. It is not known, for example, whether staff in residential settings are more or less likely to report abuses than those in other forms of care. It should be noted that in the Netherlands incidences of sexual abuse between clients and staff have to be reported. However, the authors of the studies also note the inconsistency and lack of uniformity in the reporting of abuse within the case files. This contributes directly to a lack of understanding of the nature, extent, and prevalence of abuse of disabled children.

Hoffmann and colleagues (2020) conducted a retrospective study of people aged 14 to 91 who had childhood experiences of hospitalisation in Germany. The data gathered identified differences in the experiences of maltreatment by staff between children who were hospitalised in psychiatric care (n=39) and those in paediatric or general hospital care (n=456). Whilst most respondents did not experience maltreatment in either setting, 33 per cent of respondents who had been in psychiatric care reported harm, whilst of those in paediatric or general hospital care 17 per cent reported harm. Although the study does not specifically identify children who were hospitalised in psychiatric care as being 'disabled', under our search terms we have defined poor mental health as a disability, and the fact that a child was hospitalised with an average stay of 34.4 nights indicates that this was at a level that would have had a 'significant impact' on their lives (Hoffmann *et al.*, 2020). The article identifies the limitations of a retrospective study, including that recollections may fade, and that some participants may not have wished to divulge abuse or maltreatment nor declare whether they had been hospitalised. Furthermore, the study highlights that the participants may have not been able to distinguish between treatment that was indeed maltreatment, or treatment that was necessary. The authors also draw attention to the fact that definitions of neglect and harm may not have been fully understood by respondents to the questionnaire. Limitations aside, the study provides useful data.

As demonstrated in *Part 1 – Context*, the lack of evidence means that it is difficult to quantify specific numbers of disabled children known to be abused within a residential setting in Scotland and in other provinces of the UK. The evidence base on the extent of abuse is limited to the findings of inquiries such as the Helsley Review, which itself is limited to one provider of a number of disabled children's homes and a small sample of children (albeit over 100 disabled children). As will be explored, the abuse of disabled children in residential settings is hidden by the nature of the settings themselves. Furthermore, when concerns are raised and found

– as illustrated by several media reports and journalistic exposés – there appears to be a lack of formal and robust reporting or inquiries.[12] Thus, whilst there is some prevalence data, this is not sufficiently rigorous to establish the full extent of abuse of disabled children within residential settings.

Nature of abuse

Drawing attention to the evidence on the nature of abuse, such evidence is limited by the focus of the studies themselves. Both Wissink and colleagues (2017) and Euser and colleagues (2016) specifically focused on child sexual abuse. Hoffmann and colleagues (2020), looking at childhood experiences of hospitalisation, identified emotional, sexual, and physical abuse, and neglect within psychiatric settings, with physical harm being the most prevalent. However, they acknowledge that cultural, political, social, and healthcare changes regarding approach over the decades mean the experiences of younger adults may differ from those of older participants (eldest aged 91), but it was not possible to differentiate this.

The 11 case reviews or reports present a mixed picture of the nature of abuse of disabled children in residential care settings. There were two cases (Stanbridge Earls School Review, 2015; ‘Craig’, 2022) of abuse by other children within the placement, and one case of sexual abuse by a male carer within the placement (Child X). Physical restraint was present in three cases (Child E, 2018; Child MM, 2017; ‘Beth’, 2019). ‘Beth’ (2019) and Child MM (2017) were subject to ‘dehumanising’ events and conditions, with ‘Beth’ also being sedated and stripped naked.

It is significant that of the 11 individual cases analysed, seven involved significant harm outside the placement. This included one case of gang-related sexual exploitation (‘Ruby’) and three cases that resulted in the death of the child (Child E, 2018; Child N, 2016; ‘Isabelle’, 2020), although not by the hand of their carers within the residential placement. These underline an issue that emerged from the evidence we reviewed (including within the Hesley Review) concerning the vulnerabilities of disabled children within residential settings to exploitation and potential neglect, and the institution’s failure to protect children in their care. This will be elaborated further below.

The Hesley Review (2022, 2023) is particularly significant and offers a detailed picture of the nature of abuse within residential care of disabled children. The 108 children

---

[12] See *Grey literature*.

who were the subject of this investigation were described as among the most vulnerable children in society. The review identified that children had experienced

- systematic and sustained physical abuse and violence from staff and other resident children. This included repeated and dangerous use of physical restraint and physical abuse as a form of discipline. Most cases concerning physical abuse had not been investigated.

- emotional abuse, cruelty, and neglect. Bullying and taunting were a feature of life in the settings. Emotional abuse was described as significant and varied, which manifested itself in children rocking or headbanging to self-soothe.

- sexual harm from the breaching of boundaries between staff and children.

- poor quality of care, resulting in children being deprived of their liberty and denied access to their communication method (e.g. PECS),[13] rendering them voiceless and powerless. The review describes the frustration of a child whose communication was not understood and who was thus isolated. This led to an increase in the child's behaviour deemed 'challenging' and a subsequent increase in the use of physical restraint. The review concluded that this was completely inappropriate in these circumstances.

- medical needs not being met, including medication being misused, maladministered, and disposed of inappropriately.

The detailed descriptions of the abuses experienced by the children included in the Hesley Review reveal the shocking breadth and depth of harm. The review draws attention to the contemporary and multi-faceted nature of abuse of disabled children in residential settings.

The New Zealand studies (Royal Commission of Inquiry, 2024b; Mirfin-Veitch *et al.*, 2022) gathered narratives of the lived experiences of disabled survivors of abuse within residential care, evidencing repeated and multiple incidences of sexual, physical, and emotional abuse, seclusion/isolation, and the use of restraint. Survivors also reported being denied affection and a nurturing and stimulating environment.

---

[13] PECS (Picture Exchange Communication System) is a communication system that uses pictures or symbols to help a child communicate their wants and needs. It is designed to support children who find it difficult to initiate communication and may also have limited spoken language.

These studies also demonstrate the long-term impact on disabled people of childhood abuse within residential care.

Institutional abuse

Gil (1982) identified three distinct forms of institutional abuse: direct (or overt) institutional abuse, programme abuse, and systemic abuse. This provides an important framework for considering how change needs to happen at multiple levels.

Direct institutional abuse refers to physical or emotional abuses imposed by a caregiver. Within the 11 individual cases of serious harm to a disabled child in care, we found little evidence of direct institutional abuse perpetrated by residential care staff, other than the serious case of sexual abuse of Child X (2024). However, evidence from Euser and colleagues (2016), the Hesley Review (2022, 2023), Hoffmann and colleagues (2020), Mirfin-Veitch and colleagues (2022), New Zealand Royal Commission of Inquiry (2024b), and Wissink and colleagues (2017) clearly shows that direct institutional abuse has occurred historically and still continues.

Programme abuse includes residential practices endorsed and accepted by staff but considered abusive by an external observer. The Hesley Review highlights the issues of communication tools being unavailable or removed from children as a punishment, the denial of cultural and language needs, and the misuse of medication. The Stanbridge Earls School Review (2015) found that staff's response to Child F (who was sexually assaulted by another child) did not take into account the child's learning needs, nor did it address the culture within the school.

Within a number of different settings, including in secure settings (youth justice) for children with and without disabilities, the use of restraint and seclusion may be used, but, by law and according to policy within Scotland and the UK, the practice should be used only in highly restricted circumstances. However, Article 39, in its statistical report on children and young people in secure mental health inpatient care, found that: 'In May 2020, 55 children with learning disabilities and/or autism were subject to (recorded) instances of restraint. This included 85 instances of prone restraint[14] used on 20 children' (Article 39, 2021: 6).

The individual case review for Child E (2018), the report for 'Beth' (2019), and the Hesley Review (2022) provide ample evidence that restraint and the management of

---

[14] Prone restraint on children refers to a method of physical restraint where a child is held in a face-down position, typically on the floor or another surface, and prevented from moving or getting up. This practice is considered highly risky and can lead to serious injuries or even death.

behaviours through seclusion have been used routinely within some settings, with serious harms to children's mental, emotional, and potentially physical health. The Hesley Review highlights a 'culture of abuse and harm' and ineffective management that failed to challenge this. In particular, attention was drawn to the lack of training in restraint techniques and their inappropriate use. The review reports on a case of restraint being used on children when there was a specific request from the placing authority that this not be used.

A collective failure to understand a child's behaviour and lack of understanding of the need to de-escalate within the setting may also mean the communication of needs by a child may be dismissed. This can lead to an escalation of self-harm or 'challenging' behaviour. For example, in the case of 'Beth' (2019), the review states: 'The ethos of care [meant] that there was a failure to recognise the communication of unmet needs expressed by such behaviours and furthermore normalised profound restrictive practices' (paragraph 1.6).

Systemic abuse reflects the inability of a structure to guarantee the protection of children in care. It was evident that the needs of many of the disabled children considered in the 11 individual case reviews were not met due to systemic failures. Common systemic failures identified in the reviews included unsuitable placements and disability-related needs being unmet. Child MM's review (2017), for example, identified emotional and physical harm as a result of inappropriate placements. The review for 'Isabelle' (2020) identified systemic failures in: communication; information sharing; transition planning; and understanding of autism, individual needs, and presentation.

An issue particularly pertinent to meeting the needs of disabled children in care is the use of deprivation of liberty safeguards (DoLS). There may be instances when depriving someone of their liberties through restraint and/or restrictive interventions is necessary for their own and/or others' protection and safety. Within a residential setting, locked doors preventing a person leaving a building, or restrictions on who someone is allowed to associate with are examples of DoLS. Whilst some measures can be justified as age-appropriate safeguards, depriving a person of their liberty to freedoms enjoyed by the general population of their peers must be justified under law.

Within England and Wales, the DoLS, introduced as an amendment to the Mental Capacity Act 2005, ensure that these restrictions are necessary and in the person's best interests – hence the legal 'safeguards'. Roe (2023) draws particular attention to concerns over the inappropriate use of the deprivation of liberty (DoL) application process and the lack of representation of children and their parents within it. Her analysis of DoL applications between July and August 2022 (n=208) found that 34 per cent of children were recorded as disabled and 40 per cent as having neurodevelopmental needs. Roe identifies in particular that disabled children form a distinct group, with DoL applications being made on the basis of children with learning and physical disabilities needing support/supervision. She states: ‘In around a quarter of cases, a deprivation of liberty was sought primarily due to a need to monitor and supervise a child to manage their care needs and/or to place restrictions on their liberty to manage challenging behaviours that were linked to the child’s disability’ (Roe, 2023: 20).

When considering systemic abuse, the fact that a child or young person is deprived of their liberty to ensure that their support needs will be met indicates there may be systemic failures in providing for their needs without this most restrictive practice. Evidence from the Hesley Review and the Children’s Commissioner for England (2024) points to the lack, or insufficiency, of provision for a child’s needs, leading to placement failures, fractured relationships with family and carers, and escalation in behaviours that in turn led to the situation where a DoL order was required. Wider issues of the improper implementation of DoL orders will be further discussed in the section *Deprivation of liberty orders*.

In summary, we found evidence of all these forms of institutional abuse, albeit within a very limited evidence base. It is important to highlight that there has been a lack of attention in research, possibly in part due to a lack of funding, to examining the particular issue of systemic and programme abuse. This points to the need for more sophisticated research design. Without data of this nature, it is easier for those in power to ignore the situation or dismiss it as single incidences rather than a systemic issue.

What are the risk factors for disabled children?

Through analysis of the available evidence, four key areas of risk factors for the abuse of disabled children in residential settings can be identified. These are:

- a lack of appropriate placements
- risk factors within the institutional setting
- inadequate external monitoring, scrutiny, and national policies

- risk inherent to disability-related factors.

Each of these will be examined in turn below.

A lack of appropriate placements

This section explores how systemic gaps in the provision of residential care, including lack of placements, placement instability, distance from home, and planning failures, can all contribute to an increased risk of harm for disabled children. The evidence from the individual cases and the Hesley Review illustrates a lack of resources and adequate provision to meet the needs of this group of children. This directly impacts on the availability of appropriate residential placements and placements close to home, and on the ability of services to adequately plan and assess risk when placing disabled children within care settings. Inappropriate placements can lead to an increased risk of harm to disabled children when staffing and training are inadequate and the service provision is not appropriate to meet the needs of the child.

Insufficient provision and inappropriate placements

The Children's Commissioner for England (2020) detailed how children with complex mental and physical health needs or children who have been subject to sexual and physical abuse are among the most vulnerable, yet the standard of care given to them is variable. The briefing highlights the insufficiency of available and appropriate provision, with children left on long waiting lists for suitable placements and/or experiencing placement instability. Drawing attention specifically to secure children's homes, the Commissioner identified that when placements cannot be found in these settings, children are being detained elsewhere, often in accommodation that is unsuitable for their needs. Similarly, MacAlister's (2022) review of children's social care in England identified that there are too few suitable places to meet the needs of children who may be a danger to themselves or to others, or for those who are being exploited. Sometimes these children are placed in unregistered homes because no alternatives are available. The lack of available and suitable places in secure children's homes and appropriate mental health provision was identified as contributing to this. MacAlister (2022) also highlighted how registered homes are less likely to offer placements to this group of children because such children are deemed a higher risk, and this could consequently affect their Ofsted rating. Taylor and colleagues (2014) highlighted the lack of services for disabled children in Scotland, which suggests that children are placed in settings where their needs are not being met.

Ofsted (2024b) reported that a lack of suitable homes for children with complex needs and homes' reluctance to accept referrals for children with complex needs lead to local authorities resorting to placement they would prefer not to use. In addition, children with complex needs are also frequently being placed out of area, or are experiencing multiple moves, thus disrupting the potential for stability and appropriate care. A report by the Care Inspectorate (2022a) raised concerns about the use of long-distance and, in particular, cross-border (from other UK jurisdictions) placement of children. Children could be placed at considerable geographical distance from their home, family, friends, and community, and the transition back to their home and community at adulthood is often ill-planned. Gatwiri and colleagues (2024) also highlight a system in Australia that has the inability to offer appropriate, stable placements that specifically meet this group's needs, such as providing access to communication, understanding their behaviour as a form of communication, and delivering compassionate care that values them as human beings.

The Lenehan Review (2017) had highlighted the need to commission services for disabled children with significant needs. Yet these concerns were still noted within the later evidence we reviewed on cases of harm of disabled children. The SCR for 'Isabelle' (2020), for example, identified that 'resources are not currently designed to meet the needs of some young people with complex needs, including Autism, running the risk that the care they receive is inappropriate' (p.16). Many of the other children subject to a SCR as well as 'Beth' (report) had experienced multiple placements; it appears these were often unsuitable in terms of meeting the child's disability-related needs, and this instability was a factor in the escalation of emotional and behavioural difficulties and the poor mental health of the children involved.

Unmet needs before and during residential placement

Similar concerns were highlighted within the Hesley Review which also draws attention to the unmet needs of disabled children prior to placement in residential care. Their detailed analysis of 12 of the children included in the review illustrated a long history of unmet needs prior to placement that had not been addressed locally by services. This included a number of known adverse experiences relating to abuse and neglect in half the sample (although where this abuse had occurred is not recorded) and high levels of multiple placements and educational disruption. The review revealed that whilst these challenges were known about by services, there had been little intervention to address them. It was highlighted that the child's disability had become the focus, with little attention given to these other concerns. Other studies have also noted how a child’s disability can overshadow the identification of and response to abuse in these cases, albeit within intra-familial harm (Taylor *et al.*, 2014; Stalker *et al.*, 2015) or exploitation (Franklin *et al.*, 2022).

The analysis undertaken by the Hesley Review showed that many of the factors that may have prevented institutionalisation – such as good support following diagnosis, short breaks for families, family support, and robust planning when educational placements broke down – had not existed. Significantly, the review identified a pattern of placements breaking down outside of formal processes, often leading to crises rather than planned transitions supported by a thorough review of the child’s and family's needs.

Out-of-area and long-distance placements

The Hesley Review provides a recent and comprehensive exploration of the impact of the lack of quality residential provision to meet the needs of disabled children, particularly those with complex health, learning, and communication needs. Summing up the many concerns raised above, the review clearly illustrated that often when children in this group are placed in residential settings it is at a time of crisis for families. Services have a limited range of options and placements to support the children. This can lead to children being placed far from home, thus increasing their vulnerability as they can become isolated from family and are seen only infrequently by outside professionals who have responsibilities to safeguard them. Importantly, the Hesley Review concluded that some children could or should have had their needs met in their local community, enabling them to remain with their families. This leads to the question of service commissioning and more appropriate home-based or community-based provision as an alternative to residential care.

The Hesley Review drew specific attention to the distance between the child’s family home and the setting in which they were placed. The average distance from home for the 108 children placed at Hesley’s children’s residential settings was 95 miles, with children coming there from all over England, some from over 250 miles away. One child under the age of 10 was placed almost 180 miles from home. The limited options available meant that in practice, a placement at a considerable distance from a child’s home was seen as the only viable option, exacerbating a closed culture and denying disabled children their right to a family life. Such distances meant that opportunities for the children to see parents, siblings, and professionals such as social workers were severely curtailed, although there was evidence of some local authority social workers taking this responsibility very seriously. Parents also faced huge financial barriers to visiting their children, particularly where local authorities did not provide support with travel costs. Given that many disabled children placed in residential settings have communication needs or communicate non-verbally, the importance of face-to-face contact with family and/or professionals who are outside the setting, know the child, and can identify changes in their communication, behaviour, or demeanour that may indicate signs of harm is an important protective factor.

Out-of-area placements were also a feature in seven of the individual case reviews analysed. For 'Isabelle' (2020), placements out of area were a result of insufficient resourcing within the local authority. Communication and continuity of care are important, but the significant case review (SSCR) found that 'some agencies do not support practitioners to provide care to young people who are placed out of area, resulting in unnecessary disruption and discontinuity for the young people' (p.19). It appears that in many SCRs placements out of area were often sought after residential or foster placements local to the child's family had broken down. The cumulative impact of out-of-area placements and repeated breakdowns of these placements was a factor in the negative outcomes for this group of children and indicative of systemic failures to meet the child's needs, and thus a potential risk factor for abuse. This was particularly evident in the reviews for 'Emily' (2024), 'Ruby' (2021), Child MM (2017), and Child F (2022).

Placement instability and systemic failures

Placement instability and the failure to plan adequately for disabled children's needs are factors that emerge consistently across both case and institutional reviews. The lack of appropriate placements to meet the child's needs, particularly around communication, and the lack of suitable placements nationally for children with complex needs were raised within a number of the case reviews ('Emily', 2024; 'Isabelle', 2020; Child X, 2024; 'Beth', 2019) and within the Newcastle–upon-Tyne review of the sexual exploitation of adults and children with care and support needs (Spicer, 2018). Six of the children subject to SCRs had experienced a high number of placements (more than five) that had broken down. Child X (2024) had experienced 38 placements; Child E (2018) had had 10 placements, nine of which were residential; and Child N (2016) had had 13 placements, seven of which were residential. 'Isabelle' (2020) had had at least four placements during the last three years of her life.

Brown and colleagues (2016) found that the high prevalence of child sexual abuse and child sexual exploitation in residential care was due to the characteristics of residential care arrangements, including placement instability. Multiple placement moves destabilise the children and young people, limiting their abilities and opportunities to develop the kind of trusting relationships that could foster security and stability. Further, Rahilly and Hendry (2014) detailed how the predominant type of abuse of children in care is abuse by 'the system', which is characterised most obviously by multiple placements and being moved to cut costs.

The SSCR for 'Isabelle' (2020) found inconsistent understanding of her autism. Being placed out of area at the time of her diagnosis contributed to communication difficulties between services and barriers to the provision of educational and health services in particular. This clearly contributed to overall failings in her placement. Similarly, in the SCRs examined, the full extent of a child's needs was not always identified prior to placement, especially the emotional and psychological impact of previous trauma. Unmet or poorly met educational, emotional, and mental health needs were identified as issues in almost all cases. For example, Stanbridge Earls School (2015) was a specialist placement for Child F, but there had been no diagnosis of the child on entry to the placement. It should, however, be noted that the placement was funded independently by the child's parents.

The threshold of when poor-quality residential care should be considered abusive and neglectful is a vital consideration but not one discussed within the evidence gathered here. What we can highlight from across the evidence collated from Hesley and the individual child reviews or reports is that when decisions are made about the placement of disabled children, safeguarding considerations are not always fully risk-assessed and planned for. This includes risks for the child being placed and for other children already living there. Nor is sufficient consideration always given to whether the full range of the child's needs can be met in a particular placement. In the UK the responsibility for ensuring this is suitably assessed lies with both the placing authorities and the setting. The Hesley Review and the 11 case reviews highlighted that inadequate planning and risk assessment often led to significant increased levels of 'challenging' behaviour, anxiety, trauma, and unsafe environments.

In summary, inadequate provision to meet the needs of this group directly impacts the availability and stability of appropriate residential placements. This also appears to have a direct impact on adequate planning and risk assessment when placing disabled children, leading to their needs and safety not being properly assessed and understood prior to their entering a placement. Inappropriate placements can lead to an increased risk of harm to disabled children, especially when their needs and communication are not understood. Being placed a long distance from home and from the responsible authority can leave disabled children isolated and at an increased risk of harm and/or in a position where harm can go unnoticed.

The following section builds on this by examining how supervision, staffing, and training within residential settings further increase risk, particularly when service provision fails to meet the specific needs of disabled children.

Risk factors within the institutional setting

This section identifies key areas of risk within the institutional settings. A recurring theme is the inability of institutions to understand and meet the needs of disabled children placed within their care, often linked to poor training, supervision, and a failure to follow the care plans of individual children. Alongside this, the evidence draws attention to the failures of placements to meet basic human needs, the inappropriate use of restraint, and the intersectional needs of disabled children. The risks associated with living with others and the inadequate assessment and monitoring of those risks will also be explored.

It is clear from the analysis of the individual case review or report that there was a gap between what some of the settings were believed to have been able to deliver when commissioned and what children actually experienced. In some instances, it was believed at the point of commissioning that a placement would be able to meet the emotional and behavioural needs of children, but other factors meant that the child remained at risk. For example, 'Craig' (2022) was abused by another child within the therapeutic setting, despite some measures being in place. Similarly, Child N (2016) was placed in a specialist care setting for attachment disorders, but the placement was unable to provide pain management and emotional support after the child became physically disabled through an accident.

Safeguarding from external risks

Risks to children were not limited to within the placement. Safeguarding disabled children includes ensuring their safety from outside risks. It is alarming that of the three SCRs where DoL orders were in place to protect the child, one child was drugged and raped by someone she met online ('Emily', 2024), one was groomed and became pregnant by a carer within the placement (Child X, 2024), and the third absconded and became pregnant (Child F, 2022).

This indicates that the institutions were not adequately prepared or trained to care for particularly vulnerable disabled children, nor were they adequately risk assessed.

The Stockport Safeguarding Practice Review (2022) stated that the failure to keep Child F safe appeared to be 'due to the placement not providing adequate staff or implementing the DoLS measures as they were commissioned to provide' (p.9).

Crucially, for disabled children in residential settings where abuse or harm occurred outside the setting, the lack of understanding by staff of the child's learning, emotional, educational, and/or disability-related needs was identified. This failure to pay appropriate attention to the child's needs increases the risk of harm as the child is more likely to become dysregulated and/or disenfranchised and distant from their potential network of support.

Leadership failures

Inadequate leadership in placement settings was a consistent factor. This leads to poor practice that significantly impacts the daily lives of children and allows abusive situations to arise and become entrenched. The Hesley Review highlighted that poor practice was allowed to flourish, with children not receiving the support that was detailed within their care plan and that the provider was funded to deliver. The review for 'Beth' (2019) detailed that care planning was in place but was not delivered, leading to appalling treatment of 'Beth' and her family. Importantly, if care and communication support is not delivered in the way required for individual children then situations can escalate, such as the overuse and inappropriate use of restraint and/or seclusion.[15] In the case of the Hesley Group, restraint was used on children when there was a specific request from the placing authority that it not be used, and specialist equipment (such as helmets for head protection and weighted blankets) were not provided. The neglectful provision for the children within Hesley also extended to poor clothing and a lack of attention to recreational activities.

Cultural and racial disparities

The Hesley Review drew attention to a clearly neglected area of research by seeking to address how and where there may have been racial disparities in the experiences of disabled children. Evidence within this review indicated that some children were denied their own culture and identity. Specific examples included that most Black female children had their hair shaved short when they arrived at the setting. At times this was against parental wishes and without consideration of the degrading and depersonalising experience for the child, the loss of the child's identity, and the

---

[15] Discussed further in the section *Control and use of restraint, seclusion, and deprivation of liberty orders*.

impact this might have on a child's inclusion within the provision. The review concluded that the cultural needs of children were marginalised with regard not only to their physical appearance but also those related to their family's language. This was also highlighted in the SCR for Child X (2024), whereby there was 'little evidence of [Child X]'s cultural needs being considered in care planning and placement commissioning' (p.10). Settings should be sensitive and accommodating to children's racial, ethnic, and cultural backgrounds. The Hesley Review's recommendations call for the promotion and embedding of culturally intelligent practice and the addressing of issues such as racial stereotyping and cultural bias. To that we would add recommendations specifically also concerning Deaf culture, identity, and language.

Risk associated with living with others within settings

Research highlights that children who engage in abusive behaviours can be a significant risk for disabled children in residential care. Euser and colleagues (2016) and Wissink and colleagues (2018) reported high levels of sexual abuse of children with intellectual disabilities by other children within the same setting. However, as previously indicated, the limitations of the two studies undermine confidence in the representativeness of these figures, particularly as the high percentages may be a result of more rigorous reporting of abuse by other children within a setting, as opposed to lower levels of reporting or recording of abuse by carers.

Nevertheless, the testimonies of disabled survivors documented via the New Zealand Commission (Mirfin-Veitch and Conder, 2017; Mirfin-Veitch *et al.*, 2022) clearly highlight that the sexual abuse of children by other children can be a common feature of institutional life. Similarly, the SCR of 'Craig' (2022) found that Child Z was known to have been a sexual risk to other children because of previous allegations, yet was not adequately supervised or supported. This led to the abuse of 'Craig' and another child within the setting. These findings highlight that disabled children may face particular vulnerabilities within peer groups in residential settings, requiring robust safeguarding strategies that are not always in place.

Issues in handling risk

Several cases demonstrate how poor institutional practice, especially a lack of risk assessments and supervision, exposed children to harm. An Ofsted (2022) inspection report for Calcot Children's Home for children with complex emotional or behavioural difficulties and/or learning disabilities identified serious and widespread failures across the setting which meant children and young people were not protected. According to the report, managers had failed to respond appropriately to serious incidents, and this had placed children at risk of harm. For example, there was a failure to take account of the risk assessments for children, which resulted in serious safeguarding incidents. Potential risks relating to sexually harmful behaviour were not assessed and no safety plans were put in place to prevent a similar incident recurring.

The evidence reviewed highlights specific failings in professional practice with regard to assessing the risks posed when placing disabled children who are known to display harmful sexual behaviours. In Wissink and colleagues (2018), of the 63 cases of children abused by other children, 23 (37%) concerned a child who had committed sexual abuse previously. The reasons for such failings to properly assess and address risk are not explored further in their data. However, as noted above, the findings of this review highlight the challenges in finding placements, placements being needed at crisis points, and too much focus on disability-related needs within assessments, suggesting a lack of attention to these risk factors when assessing and planning appropriate placements.

A more considered, trauma-informed approach to children who commit abuse of other children is needed. Some of these children may have their own histories of abuse which have not been recognised or heard and may not have received appropriate responses. A nuanced understanding of this form of abuse for disabled children in institutional settings is required to better understand how risk is assessed and managed to prevent such abuse. In addition, an understanding of how responses to this form of abuse are handled and how the children are supported to recover was not evident in publications analysed.

Gaps in education and safeguarding

Beyond risk assessment and placement planning, the lack of accessible sex and relationship education for disabled children represents a significant safeguarding gap. The lack of attention generally given to disabled children’s social and emotional needs including sex and relationship education and issues of privacy, consent, and sexuality is well established (Franklin *et al.*, 2015; Helton *et al.*, 2018). In this context, Euser and colleagues (2016) call for an urgent improvement in sex and relationship education for disabled children in out-of-home care. They highlight how caregivers frequently avoid discussing sex and sexual abuse issues with disabled children because they view it as an inappropriate topic or believe it would encourage children to become sexually active. Taboos around frank discussions of sex may create an environment where children are uncertain about what is and what is not appropriate or abusive. Research within the field of disability studies draws attention to attitudes that deny disabled young people as sexual beings, and therefore it is wrongly assumed that practice does not need to attend to these concerns (Daly *et al.*, 2019). This is not to excuse or minimise this harmful behaviour but to highlight the responsibility that professionals must take to safeguard all disabled children. The issue of appropriate and explicit sex education and support with healthy relationships is also evident in the case reviews for 'Isabelle', 'Emily', Child F (Stanbridge Earls School, 2015), 'Craig', Child X, Child F, and 'Ruby' and noted by IICSA (2022). MacAlister (2022) also identified how residential care in the UK has a lack of staff with the multidisciplinary skills required to meet the needs of children who may be a danger to themselves or others, or who are being exploited.

Taken together, the evidence presented highlights several safeguarding failures. Disabled children in institutional settings were not adequately protected from children who abuse other children, while the children who displayed harmful sexual behaviours were not given trauma-informed support that might have prevented further harm. Prevention efforts, including sex and relationship education and equipping staff with multidisciplinary safeguarding expertise, were also lacking. There remains a critical gap in both evidence and practice on how best to assess, prevent, and respond to children who engage in abusive behaviours while in residential care.

Control and use of restraint, seclusion, and deprivation of liberty orders

This section explores two distinct but related areas of restrictive practice in residential care: the use of restraint and seclusion, and the application of DoL orders. Both raise serious concerns about legality, children's rights, and safeguarding practice.

Legal and rights frameworks

Restraint and seclusion are widely reported within residential and secure settings. We have already drawn attention to these, the use of which appears to be commonplace within some residential settings, and to the issue of DoL orders. Research, however, points to real concerns as to the impact of the use of restraint and seclusion in any setting, as well as the misuse of restraint and seclusion on children's wellbeing (Children and Young People's Commissioner Scotland, 2018).

Also highlighted has been the issue of legality and whether such actions are in breach of the European Convention for the Protection of Human Rights (Council of

Europe, 1950), the United Nations Convention on the Rights of the Child (UNCRC, 1989), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006). The Children and Young People's Commissioner Scotland (2018) highlights the issues of sporadic and patchy understanding and implementation of conventions and law across Scotland regarding the seclusion and restraint of children.

The Children and Young People's Commissioner Scotland's (2018) investigation on the use of restraint and seclusion in schools noted that: 'The information provided to us by families suggests that restraint and seclusion are used disproportionately with children with disabilities or Additional Support Needs' (p.18).

However, this report does not identify whether the families were referring to residential schools, and the focus was on educational settings, not those relating to health (hospitals) or social care, a gap we have identified in this review. It is also noted that Scotland is currently in the process of considering a new Restraint and Seclusion in Schools (Scotland) Bill, which aims to ensure staff are fully trained in de-escalation techniques and that parents are informed if restraint or seclusion is used.

Restraint and seclusion in practice

The Care Quality Commission (2019) reported high levels of restraint and seclusion in specialist units for people (adults and children) with learning disabilities and autism in England and Wales. Subsequent reports by Article 39 (2021) on people with learning disabilities and/or autism in secure mental health inpatient care, and the Independent Care Review (2020) in Scotland, which listened to children and young people in secure care, also raised concerns regarding the overuse of restraint.

The Children's Commissioner for England's (2019) report, which detailed the experiences of autistic children and young people with learning disabilities who were staying in mental health hospitals, spoke of staff using physically restrictive measures as a matter of routine. In addition, the report found that whilst staff were not permitted to deliberately use pain-inducing restraint techniques in mental health wards, children reported that the techniques used could still be painful. A young female participant stated that:

> I don't like being restrained … It's not very good. I don't like leg holds … When I said I don't feel comfortable they let go. They didn't immediately, but they did when I persuaded them. I don't like it when they restrain me in my room … when there's more than 2 people in my room … I got

> restrained with an arm round my back … it strained my wrist, and it felt numb and had lumps (Children’s Commissioner for England, 2019: 17).

The Children’s Commissioner for England (2019) also found examples of the use of chemical restraint, with the sister of a male inpatient recalling:

> They were restraining him and constantly injecting him in his leg and his bum. He’d get a bump/bruise on his leg because they kept injecting him in the same place … They were injecting him to calm him down. If he shouted at them or turned away from them. They would come and restrain him, inject him, and lock him in his bedroom. They were away with the fairies once they were injected (Children’s Commissioner for England, 2019: 17).

Pinney (2017) likewise raises concerns around the appropriate use of chemical restraint. Reviewing data from England, she reported that two-thirds of children and young people with learning disabilities and autistic spectrum disorders in mental health inpatient facilities and specialist referrals had been given anti-psychotic medication regularly over a period of 28 days, with 28 per cent also being given ‘rapid tranquillisations’ (sedation). The disparity between levels of restraint of disabled children compared with non-disabled children is also found in the USA within two studies which looked at the records of hospitalised children. O’Donoghue and colleagues’ (2020) study on the use of restraint or seclusion of children aged 5 to 12 with, and without, intellectual disabilities and/or autism during psychiatric hospitalisation found that children with intellectual disabilities were more likely to be restrained than those without. Calabrese and colleagues (2024), in their study of data collected over years of recorded incidences of restraint (chemical and physical) for all children, found that children with an autism diagnosis were ‘significantly more likely’ to be restrained ‘involuntarily’.

Steckley’s (2017) study on the use of restraint in residential settings, including residential schools and secure care, found that some children interviewed spoke of times when they had actively sought to be restrained as a catharsis – that is, as a means to emotionally re-regulate. It is unclear if any of the children interviewed were disabled. In contrast, the evidence of adults recalling being restrained in the New Zealand studies (Royal Commission of Inquiry, 2024b; Mirfin-Veitch *et al.*, 2022) and in Hoffmann and colleagues’ (2020) and Radford and colleagues’ (2017) studies demonstrates the long-term impact of restraint on their wellbeing.

Impact on children and failures in monitoring

Evidence from families, children, and research studies highlights the physical and psychological impacts of restraint (physical and chemical) and seclusion, as well as significant gaps in monitoring. The use and impact of restraint remains a contemporaneous issue. The Challenging Behaviour Foundation (2020) gathered evidence from parents of 720 disabled children across the UK. Parents described significant physical and psychological impacts on their children, including nightmares, fear of school, trauma, post-traumatic stress disorder, and deep psychological terror. Caldwell and colleagues (2014) found that physical restraint led not only to physical injuries but also to a loss of self-respect and dignity. Such occurrences were reported to impact on relationships within the setting and lead to a loss of trust.

Furthermore, witnessing restraint can impact on children and young people in the setting, resulting in feelings of fear, lack of safety, and mistrust. Fatalities as a result of restraint have been reported by Nunno and colleagues (2022) in their study of restraint of children and adolescents in the USA from 1993 to 2018. A total of 36 children died in psychiatric centres or centres for disabled children. It is not clear if these were all within residential settings, and nor is the nature of the restraint used that led to these deaths mentioned, the fact of death through restraint is nonetheless sobering and evidences a clear risk that it can cause harm.

Article 39 (2020) highlights the issue of seclusion of children through isolation and segregation from other children (not being allowed to mix). Seclusion could be in operation for weeks, with detrimental impacts on children. Long-term segregation and seclusion were also mentioned in the Children's Commissioner for England's (2019) report on children with learning disabilities or autism living in mental health hospitals, which described how children were secluded in 'stark, bare rooms, environments that they said made them feel like prisoners not patients' (p.1).

One of the difficulties of understanding the extent, effectiveness, and frequency of the use of restraint and restrictive practices is the sporadic and inconsistent recording and reporting of incidents and policies. The Children and Young People's Commissioner Scotland (2018), when asking Scottish local authorities for information under the Freedom of Information Act, concluded that:

> As a result of this inconsistency in recording practice and methods, collecting and comparing data on a national level, as recommended by

> the UN Committee on the Rights of the Child, is currently impractical, if not impossible. We still do not know with any degree of certainty how many incidents of restraint and seclusion take place in Scotland each year, which children are most affected, how frequently and how seriously (Children and Young People's Commissioner Scotland, 2018: 18).

The lack of accurate recording and monitoring has also been raised by Pinney (2017) in England and Green-Hennessy & Hennessy (2015) in the USA. There is a serious gap in knowledge of the use of restraint and seclusion, specifically within residential care provision for disabled children, and this is a risk in itself. If the prevalence and extent of restraint and seclusion are not known, measures to reduce and avoid their use will also be difficult to assess. Meanwhile, the negative impacts on children through restraint and seclusion continue but are rarely heard about directly from those children who have experienced it.

Deprivation of liberty orders

In parallel with concerns about restraint and seclusion, the misuse or poor implementation of DoL orders also presents significant safeguarding risks. DoLS may be necessary to protect either the child themselves or others from harm; these are drawn up within a strict legal framework with checks and balances, all to ensure the deprivation is in the 'best interests' of the child. In Scotland children can only be deprived of their liberty within secure accommodation approved under the Public Services Reform (Scotland) Act 2010 (Care Inspectorate, 2023b).

It should be noted that not all children under DoL orders are disabled children living in residential care, nor are all children in residential care under a DoL order. In Scotland there is no specific DoL legislation for children, as children and young people can only be 'deprived of their liberty' through statutory provisions, such as a compulsory supervision order, or through being placed in secure accommodation. However, the DoL orders are significant within Scottish residential care settings as when children, including disabled children, from other parts of the UK are sent to Scotland, their DoL orders are in place under the Cross-border Placements (Effect of Deprivation of Liberty Orders) (Scotland) Regulations (2022) legislation.

In its report on the experiences of children aged 13 to 17 in care, the Children's Commissioner for England (2024) found that nine of the 15 children in the study had had multiple placements prior to their DoL orders. One child, formerly subject to a DoL order, stated insightfully that DoL orders could be avoided by 'actually getting that support for the young people. If that support was there in the first place a lot of people wouldn't be in this situation right now' (Children's Commissioner for England, 2024: 26).

Providing the right support for family earlier was a feature of the Commissioner's findings, with reflections by the children and one parent who noted their experiences of 'parent-blame' rather than provision of services to address the mental health needs of autistic children.

Evidence from the Hesley Review and the case reviews demonstrates that having a DoL order in place does not mean a child or young person is necessarily safeguarded. The report identified that DoL authorisation is not well understood by practitioners in local authorities and residential settings, therefore children on a DoL order may still be at risk of harm if the order is not properly adhered to or, indeed, restricted more than is necessary. Within the case reviews analysed, three of the children were subject to DoL orders. Yet in two of the cases ('Emily', 2024; Child F, 2022), harm occurred when the child was able to leave the security of the placement without adequate supervision. The other child (Child X) was sexually abused by a carer whilst under a DoL order. Ultimately, the evidence raises serious concerns that DoL orders, unless applied with rigorous safeguards and oversight, risk undermining rather than upholding children's rights to safety and protection.

Organisational structure and management

Building on the risks identified above, organisational factors, particularly management and supervision, represent a further area of concern. This section focuses specifically on how leadership structures and oversight can affect safeguarding.

The Hesley Review noted that on paper the groups' settings included a solid leadership structure and comprehensive multi-disciplinary staff team for support and therapeutic care. There were reported expectations of staff, and a culture of learning leading to good outcomes for children. However, these were either not implemented effectively or, as the review stated, 'completely violated', meaning that statutory requirements for care and safeguarding were not being met. Similar concerns have been raised by Green-Hennessy & Hennessy (2015) when examining issues around restraint in the USA. They found a mismatch between national goals and current practice in child and adolescent residential treatment centres. This mismatch between formal policies and lived practice appears to be systemic rather than isolated.

Closed systems and lack of external challenge

A key issue in the Hesley abuse scandal was that the settings provided full packages of support for children (education and care). The children lived and were educated together and had some of the same staff across both settings, meaning fewer opportunities for any signs of abuse to be noticed. Even where there were different staff across education and care it was found that safeguarding arrangements were not coordinated. This closed setting meant that there was little external challenge to poor practice from outside agencies or opportunities for staff to share with outside professionals any concerns they may have had. There was also evidence that staff were unaware of policies relating to safeguarding and whistleblowing or did not actively use them. The closed setting also facilitated a culture whereby when staff did raise concerns, senior managers were able to minimise or ignore them. There was no evidence of a culture of reflective practice, learning from safeguarding patterns or trends to prevent further harm or take sufficient action. The review called it a ‘closed shop mentality’ (Hesley Review, 2022: 42) where in some cases there was a complete disregard for statutory duties to report safeguarding to regulatory bodies, meaning that children were not adequately protected.

The Children’s Commissioner for England (2019) raised similar concerns about accountability within mental health hospitals given the closed-off nature of these settings. Hoffmann and colleagues (2020) also highlighted the problematic nature of closed psychiatric units with fewer external contacts, meaning patients are less able to complain about their treatment; they may also have less support and care from parents or usual caregivers due to restrictions placed on them. Similarly, they point to the same staff being involved in medical care and in decision-making regarding children’s social activities and use of mobile phones, leading therefore to greater emotional dependence on staff which in turn may be exploited. Such organisational cultures, whether closed or hierarchical, undermine accountability and can allow abusive practices to go unchecked. These risks are compounded by challenges in staff recruitment and workforce capacity, which the next section examines.

Staff recruitment and workforce issues

Alongside organisational and management failings, workforce issues such as recruitment, retention, and training are important factors influencing the safety and wellbeing of disabled children in residential care.

The Hesley Review identified serious staffing issues including recruitment and retention. Staff turnover averaged 39 per cent during the three-year period under review, leading to concerns that the children were not being provided with the appropriate ratios of staff and supervision to meet the needs outlined in their care plans, nor were the identified needs in the children's individual risk plans being addressed (a risk factor already discussed in the section *A lack of appropriate placements*). Once again, these findings echo previous concerns raised by the Children's Commissioner for England (2019) concerning staff recruitment and vacancies within mental health hospitals. The report drew attention to high levels of agency staff, problems with recruitment and retention, and inadequate staffing levels. It quotes one child stating that they were placed in seclusion due to inadequate staffing. Concerns over the workforce have been a long-standing issue, with the Lenehan Review (2017) raising questions regarding whether the skills needed for working with disabled children were fully recognised, understood, and adequately valued. Recommendations from the Hesley Review included that the status and pay of staff working in residential settings needed to be improved urgently.

Emotional and relational impact on children

It is important to recognise the significant impact staff turnover has on disabled children's daily lives. This might include no longer knowing who supports them and can communicate with them, and, importantly, who has control over their body especially in terms of personal and intimate care. Turnover also can significantly impact relationship building, attachment, and trust, which affects a child's ability to feel safe and secure.

Many disabled children require specific intimate care and understanding of their communication and behaviour, and so a churn of staff who may lack the relevant experience and training can increase anxiety and trauma and create or worsen tensions. This may lead to an escalation in a child's behaviour that staff find 'challenging', leading to unsafe environments.

Training and knowledge gaps

The Children's Homes (England) Regulations (HM Government, 2015) specify that staff should receive an induction and have appropriate training, experience, skills, and qualifications to meet children's needs. Evidence gathered by the Hesley Review illustrated that these regulations were not being followed, as there was limited induction or recording of training, and staff did not have sufficient knowledge or specialist training to recognise risk to children or know how to respond appropriately. The review concluded that the culture prevented a 'learning on the job' mentality. The lack of formal training further added to the risks created by high staff turnover.

Previous reports have also identified these concerns. The Ofsted (2022) inspection report of Calcot Children's Home (a home for seven children with learning disabilities) also detailed how managers had failed to ensure staff had adequate training or experience to meet the complex needs of the children living in the home and to keep them safe. Ofsted inspections of the Hesley Group settings had also raised concerns about staff bullying each other. An Ofsted social care commentary from 2017 detailed how a lack of understanding and training around the safeguarding of disabled children can result in professionals not recognising signs of abuse or neglect. This is important because research indicates that identifying abuse of disabled children is most likely to come from observations of physical signs, behaviour, or changes in mood. Disabled children are less likely to disclose abuse and more likely to delay disclosure because of a variety of barriers, including access to communication, or people who understand their communication (Miller and Brown, 2014; Jones *et al.*, 2017).

Attitudes and values of staff in residential settings

Attitudes and values held by staff in residential settings shape the culture of care and significantly influence the safety and wellbeing of disabled children. This section draws on international and UK evidence to explore how staff values and disablist attitudes can contribute to cultures of harm and considers the importance of values-based practice in preventing abuse.

Mirfin-Veitch and Conder (2017) captured the experiences of disabled people (adults and children), particularly those with a learning disability, who were abused in state care in New Zealand prior to 1992. The report details neglect, emotional abuse, control and restraint, physical abuse, sexual abuse, spiritual abuse, financial abuse, institutional, and systemic abuse. Survivors talked about having no one for comfort, and no relationships with members of their families, as well as not having their basic care needs met. Sexual abuse was reported to be part of a pattern of sexual violence perpetrated by older peers and reinforced by staff in a culture of mutually reinforcing violence. In the same vein as Hesley, staff reported that when they recognised abuse and reported it, they were not supported by management. Whilst this dehumanising treatment of children in institutions is not unique, for the focus of this report it is important to draw attention to disablism as a form of discrimination unique to this group of children. Disablism can be seen to underpin some of the attitudes and values of staff within settings. Defined as discriminatory, oppressive, abusive behaviour arising from the belief that disabled people are inferior to others, it may involve prejudice, stereotyping, or 'institutional discrimination' against disabled people. The dehumanising treatment of children reflects not only individual or organisational failings, but broader, more systemic attitudes about the value of disabled children.

Disablism and the undervaluing of disabled children

It is within the international literature, as mentioned above, that we see more specific attention drawn to disablism. It is not directly spoken about in detail within the UK literature, although it can be seen as inherent in the way that some disabled children have been, and are being, treated by staff and management within the settings in which they are placed. This will be discussed further in our concluding comments. Disablism in child protection is discussed by Franklin and colleagues (2022) and Miller and Brown (2014), who drew attention to how society does not value disabled children as equal citizens, which has a direct impact on how disabled children are protected and supported across the sector. The Lenehan Review (2017), drawing attention to scandals of abuse at the time, stated: 'Recent scandals such as Winterbourne View, Mid-Staffordshire, and instances of sustained sexual exploitation of children, have reminded us that when we believe that the people we interact with are less than fully human we build a culture which leads to degradation and abuse' (p.10).

Franklin and colleagues (2022) reflect on how a range of disabling attitudes and assumptions can obstruct recognition of abuse and effective responses. This can include being reluctant to believe that disabled children are abused, misinterpreting disclosures and signs of abuse, and lacking a focus on the child. These factors can ultimately lead to elevated risk and vulnerability.

Drawing attention to the impact of disablism, Gatwiri and colleagues (2024) highlight that disabled children in residential institutions or out-of-home care are reported as not being listened to and treated unfairly due to disablist attitudes. Llewellyn and colleagues (2016) found that disabled children may be thought of as ‘other’, and particularly so in disability-specific settings including residential care. New Zealand’s Royal Commission of Inquiry (2024b) similarly highlighted that disabled people were not seen as valuable members of society. They were placed ‘out of sight, out of mind’ and not considered worthy of being kept safe from harm.

The Royal Commission also highlighted how ableism and other discriminatory attitudes shaped the treatment and institutionalisation of Deaf children in particular. Many Deaf children were sent to special schools at a very young age on the advice of educators or medical or health professionals. Parents of Deaf children were told that an institution was the best place for their children, so they could be taught to adapt to the hearing world. However, it should be noted that the Royal Commission reported on abuses during the period between 1950 and 1999, so whether this is still a concern is unknown. The lack of research on Deaf children was noticeable throughout all of the evidence we found.

Values-based practice

The Hesley Review highlighted the need for staff working within these settings to have the correct professional qualifications and knowledge, skills, and experience to be working with this group of children. Of equal importance, however, were staff’s values and attitudes. The review identified qualities such as commitment, compassion, and understanding of vulnerability which should be tested through values-based interviewing. Challenging disablist attitudes and developing an understanding of and commitment to social justice as well as children’s and disabled people’s rights is also vital.

Power and ‘voice’ of disabled children within residential settings

Disabled children living in residential care often experience a lack of power, control and means to voice[16] fear or harm, be seen, and seek help. Within the available evidence, there were repeated accounts of children being silenced, whether through inaccessible communication systems, poorly trained staff, or institutional cultures

---

[16] We use the term ‘voice’ to mean all forms of communication. We recognise that children can express themselves in multiple ways, including non-verbally through signs and gestures, and through their behaviour which should be seen as a form of communication.

that failed to listen or respond. These barriers can increase vulnerability, undermine children's rights, and reduce opportunities to disclose harm or ask for help.

Loss of power and agency

Many disabled children living in residential settings lack agency in their daily routines and have limited opportunities to influence decisions made about their care. In Mirfin-Veitch and colleagues (2022) the stories of abuse and violence stemmed from systems in New Zealand's out-of-home care that granted power to professionals to make decisions about how disabled children would be cared for, impacting on all aspects of personal agency. For example, one storyteller recalled:

> I did not know how to express myself. There were no tools or strategies offered to me to communicate with people around me – so I could express what I wanted and needed. It was assumed that I did not have the 'mental capacity' to communicate, and it was assumed that I had an 'intellectual disability'. No one thought to ask me what was going on for me. I was under five at this point but old enough to remember how trapped I felt in myself ('Lusi', Mirfin-Veitch *et al.*, 2022: 116).

This example illustrates the disempowerment of disabled children from being able to make decisions about or within their own lives, which can lead to their being silenced.

The Children's Commissioner for England's report (2024) on the deprivation of liberties for children with complex needs heard directly from the children and young people of their desire to be listened to, but how they often felt unheard and excluded from the decision-making process:

> I can say what I like, and people can pretend to listen, but it never gets took into consideration, ever (Child subject to DoL order, age 15, Children's Commissioner for England's report, 2024: 31).

> I got shipped here by [secure transport] and ever since, no one's asked me my opinion on do I want to be up here? How long I want to be up here. What do I want? Everyone's making decisions and it's just like, okay (Child subject to DoL order, age 14, Children's Commissioner for England's report, 2024: 35).

The Hesley Review also starkly illustrated the lack of power or control for this group of children, a lack of 'voice' in their everyday lives and in decisions taken about their care as a whole. Within the case reviews, there is also little evidence of children being engaged in decision-making about changes of placement. Lack of preparation with the child, as well as about the child, was identified in the reviews for 'Emily' (2024) and 'Beth' (2019). When some disabled children, particularly autistic children and/or those with learning disabilities, are ill-prepared for change or have things 'done to them' over which they have no control, there is a potentially greater risk of harm due to heightened emotional and regulatory responses to change. This lack of preparation can lead to increased use of seclusion and restraint, and raises concerns when staff are ill-trained to understand and deal with behaviour that is 'challenging', which should be seen as a means of communication.

This lack of power and voice of disabled children in residential settings extends to their lack of involvement in wider policy and practice developments. There is little evidence of disabled children having a voice at a national level and within everyday discourses concerning disabled children in residential settings where they are often forgotten and sidelined. Article 12 of the UNCRC provides that every child has the right to express their views on matters that affect them, and for those views to be taken into consideration. Yet evidence from the Hesley Review, and the wider evidence, indicates that disabled children placed in residential settings received little support to participate in review meetings about their care and there was little attempt to facilitate this. The Children's Commissioner for England's report (2024) found that of the 15 children or young people who participated, only seven had an independent advocate during the time they were in care and subject to a DoL order.

Communication barriers and risks of being unheard

Communication barriers, both structural and relational, can prevent disabled children from being heard, especially when trying to express their distress or report harm.

Franklin and Goff (2018) highlight the importance of placing attention on children's means to communicate within settings and to the importance of increasing a child's capacity to voice their views and understand that their views matter. This is presented as a rights issue but also as a means of protection. Put simply, if you are not taught and encouraged to express your voice (through whatever communication method), or you do not have your voice heard or recognised, this will impact on your ability to speak out if you feel unsafe or to indicate when harm is occurring. This is not unique to disabled children; however, the extra barriers to communication that this group faces should be fully acknowledged.

Robinson and Graham (2021) also draw attention to how disabled children are often silenced due to previous failures by services to respond to known abuses and when responses and therapies to recovery have not been appropriate or available. This created a climate in which several children and young people mistrusted adults in key roles and found it 'harder for them to articulate disquiet or uncertainty, especially about people in authority' (Robinson and Graham, 2021: 12). They highlight the lack of control disabled children have over so many aspects of their lives, which creates barriers to them implementing their own safety strategies, notwithstanding the fact that children should not be held responsible for protecting themselves.

Many disabled children in residential settings will have significant challenges with communication and would have difficulties in telling someone verbally about abuse – not that the onus should be placed on the child to disclose. Unmet communication needs were a significant feature identified by the Hesley Review, as was the fact that the children were not familiar with many people beyond the staff in this closed setting. This meant that opportunities to disclose abuse were limited, or – perhaps more relevant in the case of disabled children with communication needs – that the people who should have or could have spotted the signs of abuse did not have regular access to the children.

Access to advocacy and trusted adults

Independent advocacy can offer a vital safeguard for disabled children, yet many receive no such support, leaving them further isolated within the care system. Many publications called for, or noted a gap in, advocacy for disabled children within residential settings (Franklin and Goff, 2018; Hesley Review, 2023; Children's Commissioner for England, 2019). However, the effectiveness of advocacy has not been robustly investigated (Greenaway-Clarke, 2020; Children's Commissioner for England, 2019). Within certain circumstances and legislation, children living away from home are entitled to have access to an independent advocate, which may act as a protective factor. For example, 'Isabelle's' (2020) advocate was instrumental in supporting her to communicate to decision-makers her concerns and wishes around her placements. However, the Hesley Review highlighted that advocate services were rarely promoted by the institutions, and only two of the children in the review sample had an independent advocate.

It is important to also note the significance placed on defining these children as 'too challenging' for visiting professionals, such as social workers, to see the children alone and without staff from the setting present. This exacerbated the lack of opportunities to identify signs of abuse in the Hesley Group's settings. It also directly impacted on visiting professionals' abilities to build relationships with the children or be able to take on board what their lives were like and whether they felt safe and cared for. Sometimes children had two-to-one or three-to-one support workers present when a social worker was in attendance. These may very well be the same staff who were abusing the child, a point highlighted within some individual cases in an NSPCC study on disabled child protection (Taylor *et al.*, 2015).

Failures to recognise and respond to signs of abuse

When behaviour is misunderstood or dismissed as being just a part of the disability, signs of abuse can be missed and protective actions delayed or denied. The importance of outside visitors accessing these settings is drawn into stark view when the evidence from the Hesley Review states that when children did make allegations and disclosures, staff did not respond effectively (a feature across much of the evidence). Furthermore, when children with communication needs were showing signs, symptoms, and behaviours that could indicate abuse, these were not understood or responded to appropriately. Specifically, there was a lack of understanding that behaviour is a form of communication, and that behaviour that is seen as 'challenging' may be a sign of distress and unmet support needs.

Other studies have also highlighted that potential signs of abuse of disabled children are often characterised as self-injurious and deemed to be impairment-related, and are not investigated appropriately (Franklin *et al.*, 2022). Taylor and colleagues (2014) looked specifically at practitioner response to disability and child protection in Scotland. They found that: 'Other risk factors may include staff not knowing how to communicate effectively with children who have communication impairments within residential settings (where disabled children are disproportionately represented), and that signs of distress and abuse may go undetected, or perhaps attributed to the impairment' (Taylor *et al.*, 2014: 10).

The evidence presented reflects systemic failures in recognising disabled children as capable when it comes to managing their own lives, leaving them at continued risk of harm.

Inadequate external monitoring, scrutiny, and national policies

We now draw attention to the third area of risk identified within the evidence: failures in external monitoring, oversight, and national policy. These systems are intended to provide a layer of protection for disabled children in residential settings, yet the evidence points to a litany of failures, increasing children's vulnerability and risk of abuse.

Poor communication between agencies

In several of the individual case reviews poor communication and cooperation between and within professions was identified. This increases vulnerability to abuse with risks less likely to be identified, shared, and managed appropriately, and agencies working in isolation and without full knowledge of important information concerning a child. Although there was some good information-sharing supporting coordinated care and protection, a lack of, or poor, information-sharing between placements was also identified ('Emily', 2024; Child X, 2024).

Several reviews identified issues of communication between health and social care agencies. Health and nursing care should be integral to decision-making regarding a placement, particularly around sexual risk and understanding, as well as mental health services concerning mental capacity and mental health needs. This was found to be lacking in a number of cases ('Craig', 2022; Child E, 2018; 'Ruby', 2021; Child F, 2022; and 'Beth', 2019). Nurses' high workloads impacted meaningful and timely visits to children in care (Child E, 2018). Yet the importance of looked-after children's nurses in 'Emily' (2012) demonstrates their significant role in supporting disabled children.

Communication issues between the local authorities who fund places for children and the hosting local authorities can be problematic when concerns are raised that need urgently addressing within placement. This was a factor in the review of 'Craig' (2022). 'Craig' had been placed 'out-of-area' after several previous placements. When a safeguarding issue came to light, the funding local authority, which had responsibility for heading up the strategy meeting and response, did not share information either with other local authorities funding placements for children or with the host authority, and there was no joint plan or risk assessment. When communication fails between these agencies, children can be left exposed and invisible in systems that are meant to protect them.

Lack of action by oversight bodies

The Hesley Review identified that even when outside agencies and national regulatory bodies became aware of issues of concern, this still did not lead to their taking decisive action, meaning that potential or actual harm continued. The Hesley Review highlighted how Ofsted had received a number of complaints and information on possible abuse going back three years. Although these had led to more monitoring visits, including emergency inspection, Ofsted had still rated the settings as ‘good’. Following allegations from 12 whistleblowers, a further inspection by Ofsted identified serious and widespread failings and insufficient safeguarding, and notices of suspension of services were served. Other agencies also had information indicating significant problems with the Hesley Group’s settings. This included the Local Authority Designated Officer (LADO)[17] in the local authority where the setting was based, and 43 of the local authorities placing their children at Hesley reported concerns. Despite a seemingly large number of known concerns, and a system of external oversight and multiple authorities with power to act, all failed to take action to prevent harm of the children they were meant to protect. The authors of the Hesley Review concluded that professionals in multiple agencies had information indicating clear concerns but this was not analysed in combination, and each piece of information alone did not lead to the required escalation and response. Despite a wealth of information pointing to serious risks in the Hesley Group’s settings, no single agency took decisive responsibility or action, revealing systemic gaps in accountability and escalation.

Monitoring of residential placements

Alongside effective communication between agencies, rigorous and informed monitoring of individual residential placements is essential to the safeguarding of disabled children. The evidence reveals significant gaps in how oversight responsibilities have been enacted, particularly when children are placed far from home.

Failings in local authority supervision

The SSCR for ‘Isabelle’ highlighted concerns about practitioner continuity, appropriate contact, and oversight, particularly in the context of out-of-area placements. The Hesley Review and SCRs drew attention to the failings of the placing authority to enact their corporate parenting responsibilities to monitor the safety and welfare of children placed in residential settings. The Hesley Review highlighted how,

---

[17] The LADO is responsible for managing allegations against adults who work with children. This involves working with police and children's social care.

for example, sight and understanding of individual children, and their needs, likes, and communication styles were lost, and information on individual children became reliant on the setting reporting back accurately, which did not always happen. This was exacerbated by the distance from home these children had been placed, which appeared to limit the capacity of the placing authorities to undertake statutory visits. These visiting requirements are a crucial part of the monitoring and safeguarding system and require high-quality examination and reviews of care for the children, with systematic recording and follow-up.

Importantly, over half the authorities that had placed children at one of the Hesley Group's settings had concerns about the quality of information they received from the homes, but this did not lead to action. This lack of action was exacerbated by high staff turnover across all levels of social care, but this should not be seen as a justification for not challenging information held or available on a child. Shockingly, and highly significantly, the Hesley Review states:

> In situations where children with complex needs and disabilities were hard to place, the relief of finding a setting that had agreed to meet all the child's needs was so strong that detailed interrogation of the reports provided from the settings did not happen in the way that it should have done (Hesley Review, 2022: 53).

Some of the children in the Hesley case were reported to have been known to their placing authority through written records alone, indicating only a superficial oversight of the child, their needs, and their family. Fragmentation of information and responsibilities across multiple teams meant oversight of the children was lost. The result was that adequate monitoring of the placement was missing, and any concerns about the quality or safety of a child's care were not identified. Children became lost in the system.

Breakdown in the LADO role

The Hesley Review highlighted the failings of the LADO role in protecting disabled children as they had failed to act upon the increasing and significant number of allegations reported to them regarding staff at the Hesley Group's settings over a considerable period. Within England, LADOs are specifically responsible for overseeing child protection allegations made against staff and volunteers who work with children and young people within their local authority. This is an important mechanism for monitoring settings in which children are placed from multiple authorities. The collation and analysis of allegations that may come from multiple sources regarding a setting is an important protective factor to identifying failures and concerns.

In the case of Hesley, there had been failings to collate and critically analyse information from the range of sources to establish patterns of concern. The formal liaison between the LADO and placing authorities was poor, with confusion about roles and responsibilities. Within the SCRs there was a lack of multi-agency knowledge or understanding of role of the LADO (Child X, 2023). In the case of Stanbridge Earls School (2015), after the LADO made enquiries they concluded that there were no specific concerns. However, the LADO was not informed of concerns by agencies who should have raised them. An Ofsted inspector was also misled about LADO involvement. Such concerns were highlighted significantly within Hesley and in evidence to IICSA (2022). The LADO system, intended to oversee and respond to allegations against staff, was undermined by confusion over roles, poor information sharing, and a failure to detect emerging patterns of concern.

Limitations of national inspection frameworks

National inspection authorities, such as the Care Inspectorate in Scotland, Care Inspectorate Wales, and Ofsted in England, have responsibility for inspecting residential children's homes. They also have an oversight and coordination role in terms of receiving and gathering reports, intelligence, and whistleblowing concerns to understand the full picture of a setting. The Hesley Review questioned whether the inspection framework for residential settings is robust given its failing to ensure the safety of children. In particular, the authors draw attention to the need for inspectors to have relevant skills and expertise in working with disabled children and children with complex health needs, and an understanding of risk in closed cultures.[18] As highlighted throughout this report, there is a requirement for those who have responsibility for caring for and protecting disabled children to be trained and skilled in understanding specific impairments, communication, behaviour, and, importantly, how signs of abuse may be indicated and sometimes more nuanced in disabled children. The Hesley Review also stated that there was a need for intelligence to be

---

[18] In this context the authors define a 'closed culture' as a poor culture that can lead to harm, which may include human rights breaches such as abuse. The five key risk factors are (1) weak leadership and management; (2) children experiencing poor quality of care, support, and outcomes; (3) poor skills, experience, and training of the staff providing care and support; (4) staff not encouraged to raise safeguarding or wider practice concerns and not supported if they do; (5) lack of external oversight. These risk factors were adapted from Care Quality Commission (2019).

more robustly gathered and rigorously scrutinised. Inspection authorities must strengthen their approach, ensuring staff have relevant expertise and that information is gathered, interpreted, and acted upon to safeguard disabled children effectively.

Complexity within the system and lack of accountability

The Hesley Review brought into sharp focus how residential care provision for disabled children operates within a complex and fragmented system of commissioning, delivery, and accountability that undermines the ability to oversee the quality of provision and care effectively. The review goes as far as saying it is a 'confusing maze of expectations, roles and responsibilities' (Hesley Review, 2022: 4) which can render the children at the centre invisible. They concluded that 'no one body or agency had an accurate picture of what was happening and there were unacceptable delays in the robust decision making that was required' (Hesley Review, 2022: 4). At every level the children were failed by systems meant to protect them. Similarly, the reports from the Scottish Independent Care Review (2020), the English Independent Review of Social Care (MacAlister, 2022), and IICSA (2022) also raised concerns about an overly complex and fragmented monitoring and regulatory framework for residential care settings, and they all recommend substantial revision.

Inconsistency and misunderstanding in reporting requirements

The evidence presented above has illustrated that within the Hesley Group's settings staff failed to comply with statutory reporting requirements. They kept inaccurate and inconsistent records, leading to a false picture of care presented to other agencies tasked with protecting and caring for the children. Statutory regulations in England require that the registered person in the setting must notify Ofsted and the placing authority when a serious incident occurs. However, what is considered a 'serious incident' is ambiguous. Some incidents are clearly defined in the guidance and require automatic notification (e.g. a child's death or allegations of abuse). Others, however, are not as clearly defined, and it remains at the discretion of the registered person to decide whether or not to notify Ofsted. The Children's Commissioner for England (2019), for example, detailed a lack of consistency and clarity of terminology around the use of restraint and seclusion, with several different terms, in-house language, and even euphemisms used on occasion, leading to problematic and inconsistent reporting. Similarly, statutory regulations in England require the registered person to report on the quality of care for each child every six months and to include the child's views, but the Hesley Review also found that this was not adhered to. This leads to a lack of transparency and accountability. The ambiguity in statutory guidance made selective reporting and misrepresentation possible, limiting effective oversight and accountability.

Missing or inadequate safeguards

We would argue that such ambiguity in guidance allows for spaces to develop where disablist attitudes and poor values concerning disabled children and their rights to quality care and a safe place to live can flourish. Overall, these safeguards, which should inform joint planning and understanding of care between the inspectorate, placing authority, and setting, became broken across a number of the individual case reviews analysed. Other required safeguards in England and highlighted within the Hesley Review were missing. One example involves the appointment of an independent person to visit the setting and provide external scrutiny of the children's homes at least once a month (including announced visits) and to report back to Ofsted. The placing local authority was found not to have the required impartiality to be transparent and critical. What is perhaps of most significance is the fact that the review highlighted the lack of specificity for settings for children with complex needs and disabilities in The Children's Homes Quality Standards (Children's Homes (England) Regulations (2015)), which do not set out clear and specific standards for meeting these groups' needs and for keeping them safe. The Hesley Review (2022) states:

> The lack of specificity in the quality standards cannot be used to justify the poor residential care practice found at Hesley's children's residential settings in Doncaster. It is arguable, however, that in the absence of clear and specific standards, there was undue discretion for the Hesley Group to claim that they were able to provide appropriate and safe placements that could meet the needs of the children placed there (Hesley Review, 2022: 50).

In the absence of clear, enforceable standards, residential providers had excessive discretion, creating conditions in which poor practice and harm could persist unchecked.

Disqualification of staff working with children

Ensuring that unsuitable adults are prevented from working with children in residential care is a critical safeguard. MacAlister (2022) detailed how the disqualification regime for practitioners working in children's social care settings is outdated, complex, and not sufficiently robust, noting that it predates all modern methods of conducting background checks on individuals working in children's homes and other settings, such as the Disclosure and Barring Service. In addition, it does not provide managers of children's homes with the confidence that the individuals they are employing are suitably safe and qualified to work with children. This is particularly pertinent given the already detailed challenges that exist with regard to recruiting and retaining staff to work with this group of children. The report stated that given that these adults are working with the most vulnerable children across the country, a lack of confidence in the ability to check whether staff have been disqualified or not is a further risk for settings if information is not known and shared. The SCR for Child X (2024) identified issues with staff recruitment and the lack of urgency regarding concerns raised about the staff member who groomed and sexually abused Child X. Employing safe staff is of utmost importance given the particular vulnerabilities of this group of children, many of whom will not be able to 'voice' concerns if they feel unhappy or unsafe.

In summary, this section has highlighted how external monitoring and scrutiny of residential placements too often fails disabled children. Poor communication and information sharing between agencies, poor oversight of placements, an over-complex system lacking clear accountability, and outdated disqualification procedures combine to leave serious gaps in children's protection. This sits within a complex system which should provide robust protective measures for disabled children in residential settings.

Risk factors specifically related to disability

The literature examined highlights how disability, particularly in combination with residential care, can increase the risk of abuse. Brown and colleagues (2016), in their review of risk and protective factors for child sexual abuse and exploitation, acknowledged two indicators of increased risk of victimisation: being disabled and being in residential care. In *Part 1 – Context* we noted the increased risks for disabled children to be placed within institutional settings and the increased risks of abuse. Alongside the broader risks already discussed, certain features relating to a child's impairment or support needs can also increase their vulnerability to abuse.

Impairment-related vulnerabilities

Above we highlighted how risk for disabled children is heightened through systemic failings both within and outwith settings, and how this can make a disabled child more vulnerable. Here we draw attention to specific factors related to having an impairment that can also increase the risk of abuse, and which are often unique to this group of children, due to their having additional needs which require specialist support. We would argue, however, that these risks are not inevitable if service provision is adapted and adequately meets a child's needs.

Miller and Brown (2014) highlight that the risk may increase for disabled children for several reasons. These include being alone with staff for intimate care needs, the potential for over-medication, and poor feeding or toileting arrangements. Other factors include how 'challenging' behaviour is managed, as well as limited access to appropriate education, stimulation, information, and emotional support. Wayland and Hindmarsh (2017) echoed this, drawing particular attention to how, in segregated settings in Australia, disabled children are often on their own with an adult. Similarly, Kelly and colleagues (2016) detailed how disabled children are more vulnerable to abuse due to factors such as dependency on others for personal care, challenges in communication, a lack of opportunity to alert others, and a high turnover of care staff – many issues already discussed. Findings from their report raised concerns about how responsive child protection procedures are to the needs of disabled looked-after children. In particular, there were concerns that these children may be treated differently from their non-disabled peers, as they are much more likely to be voluntarily accommodated rather than placed under a court order, which means they receive less monitoring and external scrutiny.

Hoffmann and colleagues (2020) drew attention to the fact that the longer a child is in an institutional setting, particularly a closed setting, the greater the risk of abuse simply due to there being more opportunities for abuse over time. This is an important factor to highlight given that disabled children are more likely to need hospitalisation, be in receipt of short breaks or respite, and/or remain in institutional care for a longer period. These factors do not make abuse inevitable, but they do demonstrate how impairment-related needs can, if unsupported, create opportunities for harm.

The impact of Covid-19

The Covid-19 pandemic brought to the public consciousness the challenges of institutional and closed settings. The Hesley Review highlighted the impact of repeated lockdowns as an exacerbating, although not fundamental, factor in the quality of care that the children received. However, repeated lockdowns did impact on the contact children had with their families, and on visits and reviews undertaken by social workers in the final 12 months of the review period (March 2020 to March

2021). Given the children's communication needs, virtual online engagements required significant support from staff, resulting in children either not having outside contact at all or not having contact with the outside world away from the staff who may potentially have been abusive. When face-to-face visits did occur, children and young people were seen outside wearing personal protective equipment which may have impacted the possibility of seeing any physical signs of abuse. Whilst this is not unique to disabled children, it is important to note that many disabled children would have been clinically vulnerable, and their shielding from the virus often lasted a lot longer and was more intense than the requirements made of the general population. The review concluded that external professionals and/or parents and carers not being able to see the children in person was considered a major factor in the risk of harm escalating. Some local authorities successfully challenged their child's placement to permit face-to-face family contact during the lockdowns, although further details of how this was achieved are not explored in the report.

Conclusion

To conclude, in seeking to answer the research question 'What are the risk factors, and how may these differ for this group of children?', despite being able to draw only on a small evidence base there is consistency across the data. There is learning regarding increased risks through disablist attitudes and some inherent risks caused by impairment-related factors. However, most other risks can be found within residential settings themselves (closed settings, staffing, training, lack of adequate risk assessments, poor planning and quality of care, and, importantly, disabled children's lack of voice and power). Risks are also present within external systems designed to support and protect disabled children and provide the independent scrutiny of these often closed settings. The implications of these findings suggest an imperative for services to prioritise lived experiences, needs, and preferences in care planning, risk assessments and decision-making, and the need to locate issues of risk of abuse within systems. Ultimately, risk is not inherent in disability itself but emerges when systems fail to recognise and adapt to the needs of disabled children.

Protective and preventative factors specific to settings for disabled children and young people

There is limited evidence that specifically addresses protective and preventative factors concerning the abuse of disabled children in residential settings. This is likely due to the significant research design challenges in being able to identify what might have protected a disabled child. Wherever possible we have drawn on material that can offer some insights, such as Franklin and Goff (2018) which draws attention to the importance of listening to and recognising all forms of communication of disabled young people in residential care in England, and Robinson and Graham's (2021) study from Australia, which explored what supported disabled children to feel safe in institutional settings. Both studies highlight learning for potential preventative and protective factors.

In the absence of research evidence, it is important to reiterate the learning from reviews, investigations, and inquiries into failures to protect and listen to children. These made several well-thought-through recommendations, based on the available evidence. It is likely that if these recommendations were implemented fully then more disabled children would be protected and abuse prevented – although, in research terms the evidence of whether they are effective and do actually protect disabled children remains to be seen. Regardless, it is an urgent imperative to implement these recommendations, and we need evidence that, when implemented, they have done what they set out to do, which is protect disabled children.

In the UK, as data from Scotland (SCLD, 2014) confirms, the numbers of disabled children and young people in residential care have drastically declined in the last century. There has been a shift from segregation to inclusion, reflected in changes in legislation, social policy, and provision of care for disabled children. However, many disabled children continue to be placed in institutions in the UK because there is a lack of support for families and within community provision, resulting in families reaching crisis point (Hesley Review, 2023). Whilst some may argue that there will always be a need for some institutional provision, especially for disabled children requiring the most complex medical care, we argue that it should be possible to meet a child's needs within the family home. Lack of resources should never be the reason for families who have a disabled child with complex needs to be left with no option other than out-of-home care. However, we also recognise that out-of-home care may be required to keep a child or others safe.

It is worth noting that much international literature identified focuses on calling for the full deinstitutionalisation of disabled children. The context for this may be linked to the type of institution referenced, and the cultural and sociopolitical environment in which disabled children have routinely been placed into residential care or hospitals.

Early family support and community provision

The Hesley Review emphasised the need for early support for families, which might prevent children being placed in residential care. It noted that more could and should be done when disabled children are on the brink of being placed in residential care. The review highlights how professionals should, for example, be more actively exploring alternatives to residential settings and be more open to listening to, and engaging with, the perspectives and expertise of parents. Parents who contributed to the review called for more 'creative solutions' to prevent residential care, such as the commissioning of additional family-based support. Franklin and colleagues (2022) argue that in terms of preventing residential care placements much more could be done at an earlier stage by multi-agency professionals to support disabled children and their families.

When considering families in receipt of 'short breaks', whereby they may have an allocated social worker or social work assistant, the Hesley Review found that other professionals around the child assumed that this social care involvement would result in any issues being identified. This assumption led to these other professionals not escalating, increasing, or changing the child's needs. The required short break reviews became the only point where needs were identified, which was often too late as by then families were in crisis and needing more intensive support or residential placement.

The Hesley Review also emphasised the necessity of recognising a child's complex needs. Many families who contributed to the review spoke of the need for tailored support concerning their child's communication and behaviour that could be 'challenging', and how this had been a factor in children being placed in one of the Hesley Group's settings. Similarly, the Lenehan Review (2017) highlighted the importance of understanding need, causation, and treatment regarding 'challenging' behaviour. This is one of the main reasons why disabled children fall between gaps and fail to get access to appropriate services, which can result in family breakdown and the need for residential placements. The Challenging Behaviour Foundation (2020) highlights the need for a key worker, a team around the child, and early years support which could reduce the need for residential placements.

Improving the provision in schools and preventing school breakdowns

Good educational provision and the prevention of school breakdowns can also stop disabled children from being placed in residential settings. Exclusion and breakdowns in school placements can lead to crisis within families and increase the need for residential placements. Parents contributing to the Hesley Review called for more specialist support for communication and behaviour in schools and schools working in partnership with them as parents. Given the high rates of exclusions and disproportionate number of children with SEND/additional learning needs that are excluded, this is a major concern (Department for Education, 2025).

Evidence from the Hesley Review and individual case reviews identified that disabled children often experience multiple educational placements, resulting in exclusion or 'managed moves' that were poorly planned. Of note was that although only 25 of the 108 children included in the review were reported to have been excluded from school prior to placement, further analysis indicated a history of failed educational placements. The review found a 'reluctance to use the language of exclusion and to present the situation as a "managed move" process' (Helsey Review, 2022: 67). This is significant in terms of having rigorous local and national data on exclusion that can highlight the systemic challenges facing this group of children, such as accessing appropriate provision, and for accountability of individual schools. There are also legal requirements and guidelines schools must follow when excluding a child. These include specific procedures, notification requirements, and provisions for addressing exclusions through governing bodies. 'Managed moves' allow schools to circumnavigate these requirements. It is important to note that there was little evidence from the Hesley Review that these moves were indeed managed and timely, or that alternative placements were explored before the placements ended. The impact of multiple changes on a child's sense of security, safety, and behaviour appeared to be poorly understood.

Furthermore, the Hesley Review highlighted that educational breakdowns were often attributed to the child and their needs rather than systemic failures and the need for improvements or changes required within the educational system. There is clearly a requirement to improve the quality and range of educational provision and support available within the education sector, including improving access to speech and language therapy, mental health support, and educational psychologists across all aspects of inclusive education.

Voice and agency of disabled children

As discussed in the section *Power and 'voice' of disabled children within residential settings*, the lack of voice, agency, and access to communication for disabled children in residential settings is a significant risk factor, and addressing this is an important preventative action. It is striking that within the available evidence, disabled children's voices and experiences of contemporary residential care and/or of abuse in residential settings remain mostly absent. Whilst not devaluing the significant importance of retrospective testimonies from adult disabled survivors of abuse, we cannot say, for example, what disabled children think are protective factors within current settings in Scotland and the rest of the UK.

Robinson and Graham (2021) provide much-needed insight into what factors disabled children in Australia felt promoted their safety: 'These were having a safe foundational space, feeling known and valued, telling someone about problems with safety, having strategies, being educated about safety and learning from experience' (p.10).

The children identified that relationships are a fundamentally important protective factor in institutional settings. We have already drawn attention to the challenges in establishing these relationships when there are issues with workforce recruitment, retention, and a lack of training.

According to Franklin and Goff (2018) disabled children need to have access to communication and to people around them who can understand, assess, and value their communication method. Access to independent advocacy can support disabled children to communicate their needs, views, and feelings. In Scotland children with a mental disorder have the right to independent advocacy under the Mental Health (Care & Treatment) (Scotland) Act 2003.[19] The Independent Care Review (2020) called for all care-experienced children to have the right, and access, to independent advocacy at all stages of their experience of care and beyond. In England the Children's Commissioner for England (2019, 2024) and the Hesley Review (2023) recommended that disabled children should have the right to access an independent advocate. The review for 'Beth' (2021) recommended advocacy for autistic children and young people. This is seen to provide children with someone who will support them to present their views.

Despite these policy commitments, independent advocacy services are rarely documented in SSCRs and SCRs. One exception is the review for 'Isabelle' (2020),

---

[19] The term 'mental disorder' includes a mental illness, a personality disorder, or a learning disability. People with dementia and acquired brain injury are also covered by the Act. People do not have to have a medical diagnosis to access independent advocacy. See *www.gov.scot/publications/childrens-advocacy-guidance/#supporting-a-child-to-understand-and-agree-to-advocacy*

whose advocate was instrumental in supporting her to communicate her concerns and wishes.

Contact with parents/carers and family members

Supportive families and their continued and facilitated contact with their disabled children are considered a major protective factor for such children in residential care (Hesley Review, 2023) and the most important mechanism to disrupt closed cultures. Parents and family members know their children and their communication method, and can tell when things are not right. As noted in the section Risk factors specifically related to disability contact can be ruptured by long-distance placements or other factors, such as the Covid-19 pandemic. Not being able to see their children causes parents and families significant distress, and communication barriers mean that other verbal or online mechanisms are not a viable option for some disabled children. Parents and family members should be able to see their children, unless there are very specific justifiable concerns which do not allow this or the child does not want to see them.

Four individual case reviews highlight the role of parents as advocates not just in raising concerns about abuse but also about the appropriateness of the care being given to meet the specific needs of their child. However, it should be noted that contact alone does not mean a disabled child is protected. As evidenced in the Hesley Review sometimes parents raised concerns but were not listened to.

While family contact can serve as a vital protective factor, it cannot substitute for the consistent presence of skilled, trusted professionals within the care environment. The following section explores how staffing continuity and clear professional accountability should also play a critical role in safeguarding disabled children in residential care settings.

Outside scrutiny and not losing sight of the child

When disabled children are placed far from home in closed settings without outside scrutiny and/or contact with their families, abusive cultures can more easily develop and flourish. We have presented evidence on how agencies at all levels can lose sight of the child and not fulfil their duty to provide external scrutiny. Concerns were noted within the Hesley Review regarding the role of the LADO and its effectiveness in this case.

The Hesley Review noted that some social workers from placing authorities travelled 200 miles to visit children, staying overnight to ensure they spent time with the children in their care so that they knew them and were assured that the care they were receiving was appropriate and safe. This led, for example, to one authority bringing reviews forward because they noticed children were losing weight. The need to spend time with the child, understand them, and recognise changes meant that at least in this instance sight of the child was not completely lost and provided some protective factors.

The Hesley Review and individual case reviews identified the need for an improved care system to support earlier identification, oversight, and intelligence gathering. The review's recommendations focus heavily on trying to improve the national inspection process for disabled children in residential care. They highlight, for example, the need to jointly inspect settings with care and educational facilities at the same time and improving inspection training concerning closed cultures in disability settings. They also call for inspectors to have the required knowledge, skills, and experience to conduct inspections in settings where children may be non-verbal and require someone who understands multiple communication forms.

A skilled and trained workforce

It is widely recognised that the workforce tasked with looking after and protecting disabled children should be trained and skilled in doing so. A protective factor must be to have staff trained and qualified in their roles who have the knowledge, skills, and competencies to provide safe and loving care for disabled children. Yet the evidence consistently indicates that there is a lack of investment in a skilled and trained workforce concerning family support and community provision prior to any residential placement and within residential settings. Staff appeared to lack the required competency and knowledge to support the children within their care.

The Hesley Review calls for mandatory training, covering areas such as

- communication
- behavioural support
- trauma-informed practice
- appropriate use of physical restraint

- clinical competencies to meet the complex healthcare needs and safeguarding of disabled children.

It also called for staff with cultural intelligence and an understanding of racial stereotyping and cultural bias. We would add to this an understanding of disablism, and a child and disability rights framework. The workforce needs a value base that recognises the dignity and rights of disabled children as human beings and shows compassion and care.

The Hesley Review drew attention to the wider challenges regarding the workforce who lack opportunities to access training and placements. They also note the need for this skilled work to be better paid and better promoted as rewarding and valuable. Furthermore, they call for an integrated strategy for workforce development and leadership, and clear standards and training for those working in and around residential care. The Hesley Review is not alone in calling for workforce development in children's care; this is a perennial call (see for example, MacAlister, 2022; CMA, 2022). However, it is important to note that dialogue concerning workforce development often does not include specific skills in working with disabled children and, indeed, safeguarding these children.

Staff training in restraint and alternative methods to de-escalate charged situations

The training of staff regarding the appropriate use of restraint is mentioned in Calabrese and colleagues (2024), Nunno and colleagues (2022), Green-Hennessy and Hennessy (2015), and Caldwell and colleagues (2014). The Children's Commissioner for England (2019) considered alternatives to restraint, such as measures to de-escalate or help children to regulate their emotions without harm. Biehal and colleagues (2014) found that residential care staff are better able to manage conflict when they remain calm under pressure and have developed a repertoire of de-escalating strategies, thus potentially reducing the use of restraint that causes harm. Positive training, support, and supervision can help care staff to reduce the tensions inherent in highly charged situations.

The Children's Commissioner for England (2024) found that restraint significantly reduced once a child or young person had been moved to a more appropriate setting for their needs. Key factors that accompanied such moves and therefore encouraged positive outcomes included the introduction of experienced and child-centred practitioners who had a clearly defined and compassionate approach. The Commissioner found that while the DoL authorisation for physical and chemical restraints remained in place, such actions were no longer required so frequently due to trust having being successfully built between carers and children. It is important to evidence successful cases such as these.

Staff consistency and the key worker role

Ofsted (2024) found that the most reported contributor to children's stability in placements was the commitment and consistency of staff around the child, because relationships can help children feel more encouraged and therefore comfortable with expressing their views about their care. Yet we have already noted that workforce issues are endemic to supporting the development of these relationships and have highlighted the challenges this presents for children with communication needs who rely on staff knowing their communication method. In addition, Biehal and colleagues (2014) showed that where residential homes work well, they tend to feature strong leadership and a positive culture that staff and young people can buy into and which promotes close, inclusive relationships between the staff and young people.

The Lenehan Review (2017) recommended a key worker (or named worker) for autistic children and children with mental health needs and/or learning disabilities in an inpatient setting or at risk of going into an inpatient setting. The role of the key worker, who should be based in the child's home area, should be to support the young person and their family to navigate the system. The worker can come from either health or local authority services but they must liaise across both services.

Accessible sex and relationship education

Ofsted (2017) detailed how accessible programmes to explore sex and healthy relationships and understand abuse are not always available to disabled children. As a result, a disabled child may not know how to recognise when they are being abused or who to tell. Improved sex and relationship education for disabled children, including information regarding sexuality and inappropriate sexual behaviour, was identified as a protective factor. Ensuring there is effective relationship, sex, and health education for disabled children in mainstream and special schools was a specific recommendation from IICSA (2022). Euser and colleagues (2016) also concluded that: 'Children should be taught how to recognize, avoid, decline and disclose unwanted sexual advances … openness about sexual abuse and talking about sexual contacts may lead to less of a burden for children and adolescents to disclose sexual abuse experiences, either as a victim or as a perpetrator' (Euser *et al.*, 2016: 8).[20]

The onus to report abuse must not, however, be on disabled children. There is a need for improved risk assessments concerning harmful behaviour, and staff must be better trained and supported to understand harmful sexual behaviours and feel confident to teach and support disabled children with these issues.

Prevention of placement breakdown

As considered in the section A lack of appropriate placements, there are increased risks inherent in inappropriate placements. 'Inappropriate' may include the lack of appropriate communication, planning, and risk assessment that should foreground any decisions being made about placing a child in a residential setting. Proper planning, which fully assesses a child's needs and whether the placement is appropriate for the child, and indeed for children already placed there, should also lead to a reduction in the harmful effects of placement breakdown. When a move is necessary, communication needs to be improved to ensure information is understood fully by the receiving placement. It is evident across the individual case reviews that poor or incomplete information sharing during the transition from one placement to another was a contributing factor in further placement breakdown and/or serious harm.

A national strategy for disabled children

The Hesley Review called for a long-term national strategy to deliver the right care, support, and protection of disabled children based on rigorous and effective joint working between agencies, local authorities, and partners. A national strategy should also address the need for children to be placed a long distance from home, including across all UK jurisdictions, to ensure children remain visible. The development of such a strategy should incorporate the views of disabled children and those of their parents or carers.

The Hesley Review also called for improved safeguarding guidance for disabled children which recognises the risks of closed cultures and provides direction to mitigate these risks. It is important to note that the specific guidance on safeguarding disabled children in England (Murray and Osborne, 2009) has not been

---

[20] Perpetrator is not the preferred term in the UK to describe children who display sexually harmful behaviours.

updated since its original publication, despite significant calls from across the sector for its renewal and as a mechanism to support improved practice.

Gaps in knowledge and understanding, and how these could potentially be addressed

Many gaps in the knowledge and understanding of abuse of disabled children within residential care have already been identified in this report. In this section we draw together the most salient and pressing issues, highlighting concerns around data collection, reporting, and research methodologies. We then explore areas that lack evidence which would support improved practice and policy development.

Methodological concerns within research

As highlighted in Part 1 – Context, there are challenges associated with finding specific evidence on the cohort under review. These are considered below.

Recognition and definitions of disability

Often, studies on abuses within the care system do not disaggregate or recognise the disability of the children within the sample to enable examination of disabled children as a distinct group. In addition, as mentioned in the section Residential settings, large numbers of disabled children and children with additional support needs are placed in 'non-specialist disability' provision, and their needs may not have been diagnosed, assessed, understood, or met within these settings. This results in disabled children being 'hidden' within multiple forms of residential provision. These problems are exacerbated by failures to record a child's disability within a care setting, and the challenges with definitions of disability and data collection at local and national levels, which have already been highlighted (see, for example, McTier, 2024).

Furthermore, we would argue that sometimes it is a case of data not being adequately scrutinised through a disability-related lens. For example, the Care Inspectorate analysis of SSCRs and learning reviews in Scotland (2021, 2023, 2024a) does not indicate whether a child's disability or, perhaps more importantly, the additional barriers the child may have faced due to being disabled, were a contributing factor to them being harmed.

Ableism is also inherent within the research community. This renders disabled children invisible and not a priority or focus of research funding and research design. There is an urgent need to address this and move this group of children higher up the research agenda so that they are routinely reported on. This should also extend to governmental and other reviewing structures, such as the Care Inspectorate, which often does not place the required lens on disability within reporting.

Definitions of care and care settings

Studies often do not disaggregate where children are accommodated and in which type of placement (e.g. foster, kinship, or residential). Methodological challenges are exacerbated by the fact that some disabled children in residential settings are not in formal state care and will still be looked after by their parents or carers. Some studies fail to distinguish between these groups of children, and some children may be excluded from studies which depend on care status.

Disabled children are also uniquely accommodated through the provision of residential short breaks where they are not immune to abuses. Some parents of disabled children have indicated that they do not use this provision because of fears of their children being abused (Franklin *et al.*, 2019). Rarely is this kind of provision included in studies on residential care or abuse despite some children spending a considerable amount of time within them. There is an urgent need to think more broadly and inclusively about disabled children in care settings to fully include the multiple places and status of care that this group experiences.

Definitions and measurement of abuse

As noted at the beginning of Part 3, the challenges to understanding the prevalence and nature of the abuse of disabled children that result from the lack of uniform methods of classifying abuse is well established. This can make comparisons between studies challenging, particularly when the terminology used around abuse is ill-defined.

Whether certain behaviours are seen or recorded as abusive is a particular challenge. We would argue that this is of particular concern for disabled children where it appears that some behaviours and practices can be seen as ‘more acceptable’ and less likely to be defined as abusive due to a child’s impairment or behaviour deemed ‘challenging’. The overuse or misuse of restraint or medication may be one such example. There are also forms of abuse linked to disablism which may not be readily acknowledged and recorded, for example the removal of a communication method or piece of equipment that is vital for a child’s health or safety.

There is a lack of research evidence about the serious systemic and programme-level abuses highlighted by the Hesley Review and the grey material considered. This may be because this kind of research requires a high level of funding from funding agencies as well as their commitment and understanding. This evidence gap hampers wider, in-depth understanding of systemic and programme-level abuses that moves beyond individual cases and one-off incidences.

Research on the abuse of disabled children in residential settings often relies on reports from staff. Whilst this may present fewer methodological challenges to accessing data, there are significant limitations to this approach, including under-reporting due to differences in what is termed 'abusive' by staff. Thus, numbers of abuse cases reported by staff may be lower than those self-reported by disabled children and young people, and by their parents/carers. However, if studies utilising self-reporting of abuse by survivors do not adapt and make their data collection methods accessible, disabled children and adults may also under-report abuse.

Another factor in under-reporting by disabled children and adults is that they may not have been taught or supported to recognise abuse and abusive practices, especially when this becomes part of everyday culture within a setting. For example, Ofsted and Schooling (2017) detailed how accessible programmes to explore sex and healthy relationships and understand abuse are not always available to disabled children. As a result, a disabled child may not know how to recognise when they are being abused or who to tell.

However, we should never put the onus on disabled children reporting abuse. We should also not forget that disabled children with communication and/or learning needs who are abused may require significant support and rely on others to notice the abuse. It is notable that other than the Hesley Review, material does not focus on the abuse of this group of children.

Definition and disaggregation of age

Whilst child protection processes often stop at the age of 18, disabled young people often remain in residential provision for much longer, often for their whole life. There is little evidence to support understanding of abuse and protection of disabled young people when they transition from child to adult provision. Studies on abuse of disabled people in institutions do not always disaggregate by age and thus do not enable the examination of data for children under the age of 18 or young people over the age of 18, nor for the identification of contemporary issues when the sample cover generations of experiences.

Disabled children's lack of voice

There is a distinct lack of disabled children's voices within much of the literature identified. The reasons for their exclusion often relate to adult attitudes and actions or inactions. For example, within wider studies on residential care and abuse, disabled children were noted to have been excluded from data collection; this was often based on residential staff's perception of the child's cognitive abilities. This raises some concerns about gatekeeping within institutions, and the power of staff to decide whose views are heard. This may constitute further silencing of disabled children (particularly if in a closed setting). Of course, there may be genuine ethical reasons for not allowing a child to take part in research, such as if they are experiencing trauma or have current mental health needs. Whilst we acknowledge the need for ethical, trauma-informed research involving disabled children, there is also a need for better understanding of contemporary issues of abuse in residential settings for this group of children which does not just rely on staff reports. We need research that platforms disabled children's lived experience.

Another concern when considering the inclusion of disabled children in research relates to the research community's willingness or ability to adapt methodologies to engage with this group of children. An over-reliance on standardised tools and self-report measures without adaptation will continue to render disabled children unable to participate in research and will keep the nature and extent of their abuse hidden, leading to gaps in knowledge and understanding.

Whilst not dismissing the significance of hearing from disabled adults who have experienced abuse as children, disabled children are still being abused today, as evidenced by the Hesley Review, the case reviews, and the many journalistic exposés for which we could not identify official reports. The absence of these children's voices and experiences and the lack of power this group has to inform and influence policy and practice developments somewhat echoes the powerlessness experienced in these settings whereby methods and means to communicate issues of importance, including experiences of abuse, are silenced by adults with power. Researchers, research funders, and those within practice and policy need to open up spaces for disabled children's participation in research and in the development of policy and practice that affects them. As can be seen in the few quotes used within this report, disabled children have unique, insightful, and important concerns and views which should be recognised, particularly if we are to improve policy and practice.

Acknowledgement of intersectional issues

There was some evidence within the reviews of cultural, linguistic, and identity-related abuses of Deaf disabled children, Black disabled children in the UK, and Māori children in New Zealand. The overlaying of racism and disablism in this context is not well understood, nor has it been investigated thoroughly, although it was raised in the review for Child X (2023) and by the Hesley Review. There has been a lack of attention in research to examining intersectional issues concerning disabled children, pointing to the need for more sophisticated research design which recognises the multiple identities, genders, ethnicities, cultures, sexualities, languages, and histories that disabled children have. Disabled children are not a homogeneous group, and it is important to draw attention to this within residential care practice, policy development, and research. Without research data examining abuses that occur at these intersections, it is easier for those in power to ignore them or dismiss them as single incidences rather than a possible systemic issue.

Gaps across case reviews and their availability for independent scrutiny and accountability

This review faced challenges in finding and accessing reviews, reports or inquiries on the abuses of disabled children in residential settings. This lack of access hampered research efforts to collate and learn lessons across settings. The absence of reports contrasts with the number of 'scandals' and journalistic exposés. There may be time delays in terms of the length of investigations and/or possible criminal proceedings and subsequent publication. For example, the Hesley Review was carried out during a live criminal investigation, and other criminal investigations into these known abuses are perhaps taking place. However, the time required to complete such investigations affects the ability to access learning in a timely manner and to make sure that there is accountability. This raises important questions about whether staff were held to account and prevented from working with children again.

Gaps in knowledge and understanding for practice

There are several gaps in our knowledge and understanding which would support improved practice and the training and skills development of practitioners working with disabled children. This section highlights the most pertinent of these linked to the data presented above.

Prevention of disabled children from being placed in residential care

There is a lack of research evidence about how decisions to place a disabled child in residential care are made and how families can best be supported to prevent the need for disabled children to enter residential care. The Hesley Review noted that some residential care placements could have been prevented if families had received earlier support or alternatives to residential care had been considered. It noted that more could and should be done when disabled children are on the brink of being placed in residential care and cautioned against making rushed decisions when families reach crisis point, as this can result in poor planning and risk assessment.

Risk assessment and management

The evidence reviewed highlighted how a lack of risk assessment and management before and during placements can result in significant harm for the child and in some instances for other children in the placement. There is a need for evidence on the effectiveness or otherwise of risk assessment and management and the factors impinging on effective risk assessment and management.

Behaviours and attitudes

More research is needed to better understand how professionals define and conceptualise abusive behaviours and cultures within residential settings, as the evidence considered here points to disablist and value-based attitudes that may impact on these. Alongside this, there is a need for improved understanding of required training needs, qualifications, and supervision for those working with disabled children.

Deprivation of liberty

This review of evidence found situations where staff and local authorities have been ignorant of children's rights and the appropriate application of DoL orders. There is an evidence gap surrounding the use and misuse of DoL orders, and the extent to which these offer greater protection to disabled children in residential care. The seriousness of the failings within SCRs (Child X, 2024, 'Emily', 2024, Child F, 2022), particularly where children were harmed outside of the setting whilst under DoL orders, indicates that there is an urgent need to examine this practice to ensure it provides the safety it is meant to provide.

Appropriate use of restraint, seclusion, and isolation

There is significant evidence of the harms caused to children through the inappropriate use of restraint (see, for example, the section *Risk factors within the institutional setting*). The evidence suggests that restraint is often unreported (Challenging Behaviour Foundation, 2020; Children and Young People's Commissioner Scotland, 2018) and we do not have the full picture of current practice. Robust evidence is needed on how often restraint, seclusion, and/or isolation are used on disabled children, and the factors that can support the recording and monitoring of incidents of abuse. We also need to develop a better-informed knowledge base of the very rare occasions when restraint might be needed as a last resort to prevent harm as this appears to be ambiguously interpreted.

Important issues have been raised concerning the wider issues of staff training, attitudes, and management when it comes to the day-to-day lives of disabled children in residential care whose communication may pose a challenge to others or who may be a harm to themselves. As has been argued, a lack of training and understanding in this regard can mean that situations escalate leading to the unnecessary and inappropriate use of restraint (Challenging Behaviour Foundation, 2020). There is a dearth of research on the inappropriate use of restraint and the devastating impacts this can have. Alongside this we know little about the experiences of disabled children who are restrained or placed in isolation and the longer-term impacts of restraint.

Harm outside the residential setting

As previously highlighted, seven of the case reviews examined were undertaken as a result of abuse outside the residential setting, which included sexual exploitation and abuse, self-harm, and the misuse of drugs and alcohol. Urgent attention needs to be given to understanding how these children were failed by the settings charged with protecting them, and the extent and nature of this form of abuse.

Harm by other children

The findings of Euser and colleagues (2016) and Wissink and colleagues (2018) indicate a high number of disabled children harming other children, yet we have not been able to find other studies that particularly focus attention on this form of harm in residential settings for disabled children. There are, therefore, gaps in knowledge concerning the understanding, planning, and assessment of risk when placing children, the ongoing monitoring of risk, and the need to provide provision to support disabled children to understand harmful behaviour. We also need to better understand responses to this form of harm within settings and how to prevent further harm. This is a significantly underdeveloped area.

Attention to relationship and sex education within settings and addressing the needs of disabled children who may have been abused

The evidence highlights the critical need for improved risk assessment of harmful behaviours, alongside better support for disabled children's understanding of sex and relationships. Wissink and colleagues (2018) raise the issue of care staff finding a balance between being a protector against harm and 'being a facilitator of sexual expression and pursuit of relationships' (Wissink *et al.*, 2018: 160). This balance is not always understood, as clearly evidenced by SCRs ('Craig', 2022; Child F, 2022; 'Ruby', 2021; Stanbridge Earls School, 2015). It seems that staff may feel uncomfortable discussing sex with the young people they care for, but this issue is underplayed here. Wissink and colleagues (2018) are clear in their findings that most sexual abuse occurs between peers, which reinforces the need for young people to be educated on what constitutes appropriate and inappropriate behaviour. SCRs and historical examples illustrate the serious consequences when staff either fail to protect the children and young people in their care or overly restrict them without providing appropriate education and support. Despite calls for improved training in this area, there is limited evidence of established good practice to guide staff.

Robinson and Graham (2021) highlighted that three disabled children in their study did not have symbolic language around safety. This is a safeguarding issue and a gap in education and support, and, fundamentally, a rights issue. It highlights a gap in resourcing as without the language (verbal, symbolic, or gesture) to communicate safety or harm, children cannot articulate other than by behaviour. This places them at greater risk of harm or misinterpretation. This also identifies an evidence gap in understanding if and how disabled children are supported to develop the language and skills to express concerns around their own safety. This links directly to a reoccurring theme throughout this report on the lack of priority and attention given to disabled children's voice and expression.

Advocacy

Access to advocacy is often seen as an important mechanism through which to support disabled children to express their views, and indeed it is a recommendation across several of the reports highlighted. However, there is a lack of evidence on the use of, access to, and effectiveness of advocacy. Further consideration should be given to the effectiveness or otherwise of advocacy prior to and during decisions to place disabled children in residential settings and within residential provision. Improved understanding of these issues alongside improved knowledge on the quality, training, and skills of advocates – particularly for children with communication needs – is also required.

In summary, this section details some of main gaps in current evidence and knowledge, although these are by no means fully inclusive given the dearth of research and general lack of attention given to this group of children. It is important to note that just because we do not have detailed data on the abuse of disabled children in residential settings, this does not mean abuse is not happening. Historical and contemporary personal – and no doubt painful – in-depth testimonies and small-scale investigations show that disabled children have consistently experienced systemic abuse, including abuse directly linked to disability-related factors such as disablism.

Gaps in evidence frustrate better understanding of the extent, prevalence, and, therefore, measures to address the abuse of disabled children within residential care. Alongside a major investment in research, attention needs to be given to the collection and understanding of routine data and definitions of disability to improve data. This should be coupled with a change in attitude across ‘mainstream’ research and wider examinations and reviews of the abuse of children in care to render them inclusive of disabled children. Whilst research funding to undertake this work is imperative, we should not wait to make fundamental changes that have been outlined in recommendations already available in the reviews undertaken.

Conclusion

In 2014 the NSPCC identified a lack of evidence-based research that defines the full extent and nature of abuse of disabled children, identifies the barriers to effective protection, and measures outcomes of success for interventions. More than a decade later the situation has improved little, especially regarding the abuse of disabled children in residential settings. The lack of quality academic research to support prevention and responses is dire.

In addition, the lack of transparency, accessibility, coordination, and accountability from case reviews and other investigations across the UK is stark. This hampers our ability to gain a sense of the scale and nature of abuse and learn what would support prevention and improve responses and recovery. This has considerable implications in terms of access to justice for disabled children and their families and is inherently linked to how, as a society, we view disabled children and their families. The lack of coordination and accountability also results in abuses in individual settings or individual children's cases to be dismissed as isolated events and not part of systemic issues contributing to a lack of impetus for change at national policy and practice levels. As the evidence presented here illustrates, cases of abuse are often only brought to the fore due to parental advocacy (which raises concerns about disabled children without parents, or parents who are not able to challenge systems) or whistleblowers, often at huge cost to the mental health and wellbeing of those involved. Both avenues present challenges, with the evidence indicating that parents and whistleblowers are often failed and, at least initially, not listened to, with disabled children who disclose often treated in the same way.

This report has presented harrowing examples of disabled children being failed by the system meant to protect them. The available evidence consistently highlights the increased risks for disabled children in residential care and there is some evidence indicating where policy and practice needs to change. In trying to bring together a vast array of failings and draw some concluding statements, we reiterate here a few areas. These are in no specific order and are all vitally important.

Firstly, there is a dearth of data, reviews, and studies that look at the specific context of disabled child abuse in residential settings in Scotland, despite known abuses which, even recently, have featured in the press and on TV. McTier (2024), in discussing the varying ways in which Scottish data collection on disabled children is managed, concluded that: 'The scale of this variation further confirms the lack of consistency across Scotland in how disability (and/or developmental concerns or additional support needs) is defined, understood, identified, assessed and/or recorded by practitioners' (McTier, 2024: 29).

Consequently, this study drew on learning from other countries, providing important and consistent messages from which the Scottish system could draw on in the absence of its own robust data.

A lack of data creates invisibility, and invisibility creates vulnerability. This means we do not fully understand disabled children's needs, characteristics, geographical distribution, and so on. This, of course, is not just a Scottish issue; as noted throughout this review, it is a worldwide issue emphasising the need for more attention to be paid to this group within data collection, reviews, and research. IICSA (2022) specifically recommends that the collection of data on child sexual exploitation be disaggregated by disability.

Second, most of the grey literature and findings from the case reviews point to systemic and programme-level abuse. It is important to recognise this as well as the implications this has on those in power to change and scrutinise systems, processes, external inspections, training the workforce, and so on to ensure the best possible care and protection. Many of the issues relate to systemic shortcomings, including unmet needs, inappropriate or unstable placements, lack of early help, misapplication of DoL orders, poor data recording and information sharing, workforce gaps, weak training, and managerial failures. Collectively, these form a pattern of structural risk that requires whole-scale reform. This includes consideration of a national strategy, as called for by the Hesley Review, to address the systemic nature of the failures identified.

Third, further attention must be given to disabled children's access to communication, advocacy, and staff around them who understand communication and behaviour that others may see as 'challenging'. This directly links to concerns about disabled children being silenced, and closed cultures where abuse can flourish. A lack of 'voice' has profound effects on a child's daily life, self-esteem, and confidence.

Finally, consideration must be given to the role of disablism and how consistently the data, or lack thereof, presents a picture where disabled children and their families are discriminated or treated differently on the basis of being disabled. Looking at these issues through a social model of disability and a child and disability rights framework highlights the lack of protection, provision, and participation of this group of children.

As we reflect on these findings, the question is no longer whether change is needed, but how quickly and forcefully we are willing to act. We should not still be in a place where disabled children are not afforded the attention and protection they deserve and have rights to. As the foreword to the Hesley Review by Annie Hudson, Chair of the Child Safeguarding Practice Review Panel and Council for Disabled Children, states: 'It is profoundly shocking that, in the twenty-first century, so many children who were in "plain sight" of many public agencies could be so systematically harmed by their care givers' (Hesley Review, 2022: 1).

We hope that highlighting these issues will lead to significant policy and practice change, and an impetus for research funding and attention to address the many evidence gaps.

References

Allnock, Debbie and Pam Miller. *No One Noticed, No One Heard: A Study of Disclosures of Childhood Abuse*. NSPCC Learning, 2013.

Article 39. *Children in Hospital (Mental Health)*. Statistics briefing, 1 February 2021.

Biehal, Nina, Linda Suzanne Cusworth, Jim Wade, and Susan Evelyn Clarke. *Keeping Children Safe: Allegations Concerning the Abuse or Neglect of Children in Care*. Final report, NSPCC Impact and Evidence series, 2014.

Brady, Geraldine and Anita Franklin. '"I am more than just my label": Rights, fights, validation and negotiation. Exploring theoretical debates on childhood disability with disabled young people', *Sociology of Health and Illness* 45, 6 (2023), 1376–92.

Brown, Sarah, Geraldine Brady, Anita Franklin, Louise Bradley, Nathan Kerrigan, and Carloss Sealey. *Child Sexual Abuse and Exploitation: Understanding Risk and Vulnerability*. Report, Early Intervention Foundation, 2016.

Calabrese, Mary Elizabeth, Georgios Sideridis, and Carol Weitzman. 'Physical and pharmacologic restraint in hospitalized children with autism spectrum disorder', *Pediatrics* 153, 1 (2024), e2023062172.

Caldwell, Beth, Chantell Albert, Muhammad W. Azeem, Susan Beck, David Cocoros, Trish Cocoros, Raquel Montes, and Bhagya Reddy. 'Successful seclusion and restraint prevention effort in child and adolescent programs', *Journal of Psychosocial Nursing and Mental Health Services* 52, 11 (2014), 1–9.

Cappa, Claudia, Nicole Petrowski, and Janet Njelesani. 'Navigating the landscape of child disability measurement: A review of available data collection instruments', *Alter: European Journal of Disability Research* 9, 4 (2015), 317–30.

Care Inspectorate. *Triennial Review of Initial Case Reviews and Significant Case Reviews (2018–2021): Impact on Practice*. Dundee: Care Inspectorate, 2021.

Care Inspectorate. *Report on Distance Placements.* Dundee: Care Inspectorate, 2022a.

Care Inspectorate. *Short Thematic Review of Children and Young People Placed on Deprivation of Liberty Orders – January 2022.* Dundee: Care Inspectorate, 2022b.

Care Inspectorate. *Learning Reviews for Children: National Overview Report, 1 April 2021 to 31 March 2022*. Dundee: Care Inspectorate, 2023a.

Care Inspectorate. *Position Paper – Depriving and Restricting Liberty for Children and Young People in Care Home, School Care and Secure Accommodation Services.* Dundee: Care Inspectorate, 2023b.

Care Inspectorate. *Learning Reviews for Children in Scotland. Data Report 2024. Data for Period 1 April 2023 – 31 March 2024*. Dundee: Care Inspectorate, 2024a.

Care Inspectorate. *Disabled Children and Young People's Experiences of Social Work Services: a Thematic Review*. Dundee: Care Inspectorate, 2024b.

Care Quality Commission. *Identifying and Responding to Closed Cultures: Supporting Information for CQC Staff*. London: Care Quality Commission, 2019.

Care Quality Commission. *How CQC Identifies and Responds to Closed Cultures*. London: Care Quality Commission, 2022.

Carr, Alan, Hollie Duff, and Fiona Craddock. Report to SCAI, *Literature Review on the Outcomes for Survivors of Child Maltreatment in Residential Care or Birth Families*, 2017.

Carr, Alan, Hollie Duff, and Fiona Craddock. 'A systematic review of reviews of the outcome of severe neglect in underresourced childcare institutions', *Trauma Violence Abuse* 21, 3 (2020), 484–97.

Challenging Behaviour Foundation. *Reducing Restrictive Intervention of Children and Young People.* Update report, 2020.

Children's Commissioner for England. *Far Less Than They Deserve: Children With Learning Disabilities or Autism Living in Mental Health Hospitals.* London: Children's Commissioner for England, 2019.

Children's Commissioner for England. *The Children Who No-one Knows What to Do With.* London: Children's Commissioner for England, 2020.

Children's Commissioner for England. *Children with Complex Needs Who Are Deprived of Liberty: Interviews with Children to Understand Their Experiences of Being Deprived of Their Liberty.* London: Children's Commissioner for England, 2024.

Children's Commissioner for England. *The Educational Journeys of Children in Secure Settings*. London: Children's Commissioner for England, 2025.

Children and Young People's Commissioner Scotland. *No Safe Place: Restraint and Seclusion in Scotland's Schools*. Edinburgh: Children and Young People's Commissioner Scotland, 2018.

Child Safeguarding Practice Review Panel. *Safeguarding Children with Disabilities and Complex Health Needs in Residential Settings*. Phase 1 report, 2022.

Child Safeguarding Practice Review Panel. *Safeguarding Children with Disabilities and Complex Health Needs in Residential Settings*. Phase 2 report, 2023.

Competition and Markets Authority. *Children's Social Care Market Study: Final Report*, 2022.

Council of Europe. *Convention for the Protection of Human Rights and Fundamental Freedoms*. Council of Europe Treaty Series 005, 1950.

Critical Appraisal Skills Programme. *CASP Checklist for Qualitative Research*, 2024.

Daly, Aoife, Rachel Heah, and Kirsty Liddiard. 'Vulnerable subjects and autonomous actors: The right to sexuality education for disabled under-18s', *Global Studies of Childhood* 9, 3 (2019), 235–48.

Department for Education. *Working Together to Safeguard Children 2023: A Guide to Multi-agency Working to Help, Protect and Promote the Welfare of Children*. London: DfE, 2023.

Department for Education. *Suspensions and Permanent Exclusions in England. Academic Year 2023/24*. London: DfE, 2025.

Euser, Saskia, Lenneke R.A. Alink, Anne Tharner, Marius H. van IJzendoorn, and Marian J. Bakermans-Kranenburg. 'The prevalence of child sexual abuse in out-of-home care: increased risk for children with a mild intellectual disability', *Journal of Applied Research in Intellectual Disabilities* 29 (2016), 83–92.

Fang, Zuyi, Ilan Cerna-Turoff, Cheng Zhang, Mengyao Lu, Jamie M. Lachman, and Jane Barlow. 'Global estimates of violence against children with disabilities: an updated systematic review and meta-analysis', *Lancet Child & Adolescent Health* 6, 5 (2022), 313–23.

Franklin, Anita, Geraldine Brady, and Louise Bradley. 'The medicalisation of disabled children and young people in child sexual abuse: impacts on prevention, identification, response and recovery in the United Kingdom', *Global Studies of Childhood* 10, 1 (2020), 64–77.

Franklin, Anita and Sarah Goff. 'Listening and facilitating all forms of communication: disabled children and young people in residential care in England', *Child Care in Practice* 25, 1 (2018), 99–111.

Franklin, Anita, Phil Raws, and Emilie Smeaton. *Unprotected, Overprotected: Meeting the Needs of Young People with Learning Disabilities who Experience, or Are at Risk of, Sexual Exploitation*. Barnardo's, BILD, Coventry University, The Children's Society, 2015.

Franklin, Anita, Alex Toft, and Sarah Goff. *Parents' and Carers' Views on How We Can Work Together to Prevent the Sexual Abuse of Disabled Children*. London: NSPCC Learning, 2019.

Franklin, Anita, Alex Toft, Jane Hernon, Jo Greenaway-Clarke, and Sarah Goff. *UK Social Work Practice in Safeguarding Disabled Children and Young People. A Qualitative Systematic Review.* London: What Works for Children's Social Care, 2022.

Gatwiri, Kathomi, Lynne McPherson, and Samara James. 'Experiences of children and young people with a disability in out-of-home care in Australia: a scoping review', *Health & Social Care in the Community*, 3456823 (2024).

Gil, Eliana. 'Institutional abuse of children in out-of-home care', *Child & Youth Services* 4, 1–2 (1982), 7–13.

Greenaway-Clarke, Jo Miriam. *Advocacy and 'Non-instructed' Advocacy with Disabled Children and Young People with Complex Communication Needs.* Portsmouth: University of Portsmouth, 2020.

Green-Hennessy, Sharon and Kevin D. Hennessy. 'Predictors of seclusion or restraint use within residential treatment centers for children and adolescents', *The Psychiatric Quarterly* 86 (2015), 545–54.

Harris, Neville and Sheila Riddell. 'Ensuring rights matter: England's and Scotland's frameworks for implementing the rights of children and young people with special educational needs and disabilities', *The International Journal of Human Rights* 26, 9 (2022), 1671–90.

Hart, Di and Ivana La Valle. *Local Authority Use of Secure Placements*. London: Department for Education, 2016.

Helton, Jesse J., Tatiana Gochez-Kerr, and Ellen Gruber. 'Sexual abuse of children with learning disabilities', *Child Maltreatment* 23, 2 (2018), 157–65.

HM Government. *The Children's Homes (England) Regulations 2015*. London: The Stationery Office, 2015.

Hoffmann, Ulrike, Vera Clemens, Elisa König, Elmar Brähler, and Jörg M. Fegert. 'Violence against children and adolescents by nursing staff: prevalence rates and implications for practice', *Child and Adolescent Psychiatry and Mental Health* 14, 1 (2020), 43.

Independent Care Review. *The Promise*. Glasgow: Independent Care Review, 2020.

Independent Inquiry into Child Sexual Abuse. *Children in the Care of the Nottinghamshire Councils*. London: IICSA, 2019.

Independent Inquiry into Child Sexual Abuse. *The Report of the Independent Inquiry into Child Sexual Abuse*. London: IICSA, 2022.

Johnson, Dan R., Kirstin Ferguson, and Jennifer Copley. 'Residential staff responses to adolescent self-harm: The helpful and unhelpful', *Clinical Child Psychology and Psychiatry* 22, 3 (2019), 443–54.

Jones, Christine, Kirsten Stalker, Anita Franklin, Deborah Fry, Audrey Cameron, and Julie Taylor. 'Enablers of help-seeking for deaf and disabled children following abuse and barriers to protection: a qualitative study', *Child & Family Social Work* 22 (2017), 762–71.

Jones, Lisa, Prof. Mark A. Bellis, Sara Wood, Karen Hughes, Ellie McCoy, Lindsay Eckley, Geoff Bates, Christopher Mikton, Tom Shakespeare, and Alana Officer. 'Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies', *Lancet* 380, 9845 (2012), 899–907.

Kelly, Bernadette, Sandra Dowling, and Karen Winter. *Disabled Children and Young People in Out-of-Home Care: Summary Report.* Belfast: Queens University Belfast & Office of the First Minister and Deputy First Minister, 2016.

Lenehan, Christine. *These Are Our Children*. Review commissioned by the Department of Health. Council for Disabled Children, 2017.

Lenehan, Christine and Mark Geraghty. *Good Intentions, Good Enough? A Review of the Experiences and Outcomes of Children and Young People in Residential Special Schools and Colleges.* Report commissioned by the Minister for Vulnerable Children and Families, 2017.

Llewellyn, Gwynnyth, Sarah Wayland, and Gabrielle Hindmarsh. *Disability and Child Sexual Abuse in Institutional Contexts.* Sydney: Royal Commission into Institutional Responses to Child Sexual Abuse, 2016.

Loeb, Tamra Burns, John K. Williams, Jennifer Vargas Carmona, Inna Rivkin, Gail E. Wyatt, Dorothy Chin, and Agnes Asuan-O'Brien. 'Child sexual abuse: associations with the sexual functioning of adolescents and adults', *Annual Review of Sex Research* 13 (2002), 307–45.

MacAlister, Josh. *The Independent Review of Children's Social Care*. Final report, 2022.

McConkey, Roy, Fionnola Kelly, and Sarah Craig. 'A national comparative study over one decade of children with intellectual disabilities living away from their natural parents', *British Journal of Social Work* 44, 3 (2014), 714–28.

McConkey, Roy, Fionnola Kelly, Sarah Craig, and Hasheem Mannan. 'A longitudinal study of the intra-country variations in the provision of residential care for adult persons with an intellectual disability', *Journal of Intellectual Disability Research*, 57 (2013), 969–79.

McTier, Alexander. *Are Disabled Children Visible in Scotland's Children's Statistics?*, CELCIS report, 2024.

Miller, David and Jon Brown. *'We Have the Right to be Safe': Protecting Disabled Children from Abuse.* NSPCC, 2014.

Mirfin-Veitch, Brigit and Jenny Conder. *'Institutions are Places of Abuse': The Experiences of Disabled Children and Adults in State Care*. Donald Beasley Institute, 2017.

Mirfin-Veitch, Brigit, Kelly Tikao, Umi Asaka, Eden Tuisaula, Hilary Stace, Robbie Francis Watene, and Patsie Frawley. *Tell Me About You: A Life Story Approach to Understanding Disabled People's Experiences in Care (1950–1999).* Donald Beasley Institute, 2022.

Murray, Moira and Chris Osborne, *Safeguarding Disabled Children: Practice Guidance.* Nottingham: The Children's Society, 2009.

National Society for the Prevention of Cruelty to Children. *Case Review Process in Each UK Nation*. NSPCC Learning, 2026.

Nixon, Catherine and Gillian Henderson. 'How is the provision of residential care to children under the age of 12 associated with changes in children's behaviour and mental wellbeing?', *Scottish Journal of Residential Child Care* 21, 1 (2022), 8–53.

Nunno, Michael A., Lisa A. McCabe, Charles V. Izzo, Elliott G. Smith, Deborah E. Sellers, and Martha J. Holden. 'A 26-year study of restraint fatalities among children and adolescents in the United States: a failure of organizational structures and processes', *Child Youth Care Forum* 51 (2022), 661–80.

O'Donoghue, Elizabeth M., David L. Pogge, and Philip D. Harvey. 'The impact of intellectual disability and autism spectrum disorder on restraint and seclusion in pre-adolescent psychiatric inpatients', *Journal of Mental Health Research in Intellectual Disabilities* 13, 2 (2020), 86–109.

Office of the United Nations High Commissioner for Human Rights. *International Human Rights Standards and Recommendations Relevant to the Disaggregation of SDG Indicators*. Geneva: OHCHR, 2018.

Ofsted. *Calcot Services for Children*. Inspection report, 2022.

Ofsted. *Unregistered Children's Homes*, 2024a.

Ofsted. *How Local Authorities and Children's Homes can Achieve Stability and Permanence for Children with Complex Needs*, 2024b.

Ofsted and Eleanor Schooling. *Social Care Commentary: Protecting Disabled Children*, 2017.

Oliver, Michael. *Understanding Disability: From Theory to Practice*. Basingstoke: Macmillan, 1996.

Oranga Tamariki Ministry for Children. *Safety of Children in Care*. Annual Report July 2022 to June 2023, 2024.

Pinney, Anne. *Understanding the Needs of Disabled Children with Complex Needs or Life-limiting Conditions.* Council for Disabled Children, 2017.

Radford, Lorraine, Steven Dodd, Christine Barter, Nick Stanley, and Ather Akhlaq. Report to SCAI, *The Abuse of Children in Care in Scotland: A Research Review.* Edinburgh: Scottish Child Abuse Inquiry, 2017.

Rahilly, Tom and Enid Hendry (eds). *Promoting the Wellbeing of Children in Care: Messages From Research*. NSPCC, 2014.

Riddell, Sheila and Duncan Carmichael. 'The biggest extension of rights in Europe? Needs, rights and children with additional support needs in Scotland', *International Journal of Inclusive Education* 23, 5 (2019), 473–90.

Riddell, Sheila, Neville Harris, and Gail Davidge. 'Autonomy, education and the rights of children with special and additional support needs and disabilities in England and Scotland: a new paradigm?', *Journal of Social Welfare and Family Law* 43, 1 (2021), 42–59.

Roberts, Ellie, Sarah Sharrock, Alice Yeo, Jenny Graham, Caroline Turley, and Nancy Kelley. *Safeguarding Children From Sexual Abuse in Residential Schools.* London: IICSA, 2020.

Robinson, Sally and Anne Graham. 'Feeling safe, avoiding harm: Safety priorities of children and young people with disability and high support needs', *Journal of Intellectual Disabilities* 25, 4 (2021), 583–602.

Roe, Alice. *Children Subject to Deprivation of Liberty Orders*. London, Nuffield Family Justice Observatory, 2023.

Royal Commission into Institutional Responses to Child Sexual Abuse. *Final Report*. Commonwealth of Australia, 2017.

Royal Commission of Inquiry. *Out of Sight, Out of Mind: Kimberley Centre*. Case study, 2024a.

Royal Commission of Inquiry. *Disabled Survivors' Experiences of Abuse and Neglect in Care: Guide and Key Messages*, 2024b.

Scottish Consortium for Learning Disability. *The National Confidential Forum: Estimating the Number of People with Learning Disabilities Placed in Institutional Care as Children, 1930–2005,* 2014.

Scottish Government. *National Guidance for Child Protection Committees Undertaking Learning Reviews*, 2021, updated 2024.

Scottish Government. *National Guidance for Child Protection in Scotland 2021 – updated 2023*. Edinburgh: Scottish Government, 2023.

Scottish Government. *National Guidance for Child Protection Committees Undertaking Learning Reviews.* Edinburgh: Scottish Government, 2024.

Scottish Government. *Children's Social Work Statistics: Looked After Children 2023/24*. Edinburgh: Scottish Government, 2025.

Smith, Mark and Denise Carroll. 'Residential child care and mental health practitioners working together', *Scottish Journal of Residential Child Care* 14, 3 (2015), 6–18.

Spicer, David. *Joint Serious Case Review Concerning Sexual Exploitation of Children and Adults with Needs for Care and Support in Newcastle-upon-Tyne.* Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board, 2018.

Stalker, Kirsten and Karen McArthur. 'Child abuse, child protection and disabled children: a review of recent research', *Child Abuse Review* 21 (2012), 24–40.

Stalker, Kirsten, Julie Taylor, Deborah Fry, and Alasdair B.R. Stewart. 'A study of disabled children and child protection in Scotland – A hidden group?', *Children and Youth Services Review* 56 (2015), 126–34.

Steckley, Laura. 'Catharsis, containment and physical restraint in residential child care', *British Journal of Social Work* 48, 6 (2017), 1645–63.

Sullivan, Patricia M. and John F. Knutson. ‘Maltreatment and disabilities: a population-based epidemiological study’, *Child Abuse & Neglect* 24, 10 (2000), 1257–73.

Taylor, Julie, Kirsten Stalker, Deborah Fry, and Alasdair B.R. Stewart. *Disabled Children and Child Protection in Scotland: An Investigation Into the Relationship Between Professional Practice, Child Protection and Disability – Research Findings.* Edinburgh: Scottish Government, 2014.

Taylor, Julie, Audrey Cameron, Christine Jones, Anita Franklin, Kirsten Stalker, and Deborah Fry. *Deaf and Disabled Children Talking About Child Protection*. University of Edinburgh/NSPCC Child Protection Research Centre, 2015.

UNICEF. *Pathways to Better Protection*. Geneva: UNICEF, 2024.

United Nations. *Convention on the Rights of the Child*. New York: United Nations, 1989.

United Nations. *Convention on the Rights of Persons with Disabilities*. New York: United Nations, 2006.

United Nations General Assembly. *UN Global Study on Children Deprived of Liberty*. New York: United Nations, 2019.

Wayland, Sarah and Gabrielle Hindmarsh. *Understanding Safeguarding Practices for Children with Disability when Engaging with Organisations.* Australian Institute of Family Studies, 2017.

Wissink, Inge B., Eveline S. van Vugt, Iris A.M. Smits, Xavier M.H. Moonen, and Geert-Jan J.M. Stams. ‘Reports of sexual abuse of children in state care: A comparison between children with and without intellectual disability’, *Journal of Intellectual & Developmental Disability* 43, 2 (2017), 152–63.

Appendix A – Search terms and databases searched

(child* OR "young people" OR youth OR adolescents OR juveniles OR teens)	AND disab* OR impairment OR deaf OR blind OR autis* OR neurodiv* OR special needs OR mental OR medical OR long-term health OR communication needs OR additional needs OR epilepsy, OR learning disability OR intellectual disability OR Down syndrome OR additional support needs (ASN) OR learning difficulties OR special educational needs (SEN) OR special educational needs and disabilities (SEND) OR feeble minded OR moral defective OR mental defective OR imbecile OR idiot OR backwards OR retarded OR spastic OR ineducable OR sub normal (sub-normal) OR mental* handicapped OR intellectual disab* OR dumb OR remedial OR visual impairment OR CAMH OR cripple* OR hearing impairment OR physical impairment OR mental health OR insane/mad	AND residential OR institution OR children's homes OR secure OR accommod* OR hosp* OR wards OR convalescent homes OR asylum OR special schools	AND (abuse OR harm OR safeguarding OR protection OR maltreatment OR exploitation OR neglect OR violence OR emotional abuse OR peer abuse OR medical abuse OR pornography OR abuse images OR sexting OR online harms OR seclusion OR restraint OR restrictive OR deprivation of liberty OR spiritual OR isolation OR control

The following databases were searched:

- EBSCO
- Proquest
- Assia
- Scopus

A narrative synthesis was used to assess the evidence and present the findings in this review.

Appendix B – Summary of individual case reviews

Code in text	Reference	Demographic information	Summary	Abuse or lack of provision
Stanbridge Earls School, 2015	Hampshire Safeguarding Children Board (2015), *Serious Case Review: The safeguarding implications of events leading to the closure of Stanbridge Earls School, Child F* Authors: Kevin Harrington and Jane Whyte	Child F: female aged 14/15 Out-of-area LA. As well as 'disability' (unspecified), Child F was found to have social and emotional developmental needs Child J: female. Unclear if boarder England	Independent school for children with specific learning disabilities. Co-ed, day, and boarding. Majority boys Response to Child F – boarder. Child F's parent advocating to school, police, and LA regarding abuse School not sharing information regarding sexual assaults on Child F and Child J	Sexual abuse by one or more other children. School lack of response to sexual activity Child F and others
Child E, 2018	London Borough of Barnet Safeguarding Children Board (2018), *Serious Case Review Child E* Author: Jane Wonnacott	Child E: male aged 16 Came to England aged 10. Subject to child protection plan with care order at age 13 CAMHS involvement. Mental health and emotional difficulties England	In care – cause of death drug use Not able to access specialist education due to no statement (EHCP). Sent to therapeutic settings, but short term Education – not meeting needs Nine residential settings, including out-of-area. Placement breakdowns	Death due to drug use Absent from placement – home of older male In one therapeutic setting 69 incidences of restraint in 5 weeks Lack of education meeting needs Criminal justice system involvement

			Base: England, with one placement in Wales	Self-harm Drug and alcohol use
'Craig', 2022	Tameside Safeguarding Children Partnership (2022), *Local Child Safeguarding Practice Review Craig*	'Craig': male Subject to care order Diagnosis of ADHD and conduct disorder England	Foster placement, then out-of-area care before therapeutic setting to meet needs agreed at age 9 Education provision attached to care home	Sexual abuse by older child (Child Z), who was alleged to have acted sexually harmfully towards peers prior to 'Craig's' placement in home Allegations made by Craig initially dismissed by SW and others
Child N, 2016	Barnsley Children Safeguarding Boards (2016), *Serious Case Review Using the Significant Incident Learning Process of the Circumstances Concerning the Death of Child N* Authors: Mark Dalton and Nicki Pettitt	Child N: male Age at death 15 Placed on CP register at birth ADHD? and CAMHS 'attachment disorder' Injury: permanent pain and disability in ankle. Self-medicating England	Cannabis use at age 12. This and possible ADHD contributed to placement moves Multiple placements Use of drugs to control pain of injury. MH impact of life-changing accident Criminal justice system involvement	Prior placement in specialist care setting for attachment disorders. Work not completed Placement at death: in home for 2 children with therapeutic support – majority of the time alone. Able to deal with EBD, but possibly not physical injury Death by methadone

Child MM, 2017	Surrey Safeguarding Children Board (2017), *Overview Report Partnership Learning Review: Child MM* Author: Ben Byrne, Head of Early Help and Family Services, Surrey County Council	MM: female. Age 13 at time of incidents of review Subject to care order Emotional and behavioural difficulties/ attachment issues 'Difficult to place' England	In care at age 7. Had therapeutic educational placement, then foster placement before 'series' of out-of-area placements Placement breakdowns due to behaviour Accommodated in police cell, B&B, MH facility that was not appropriate	Review identifies emotional and physical harm as a result of inappropriate care provision. 'Inhumane, degrading, and distressing – putting her and others at intolerable level of risk' Use of restraint, seclusion. Self-harm
Child X, 2024	Gloucestershire Safeguarding Children Partnership (2024), *Child X Local Child Safeguarding Practice Review* Author: Lucy Young	Child X: female Traumatic childhood. Complex emotional and behavioural needs Child X and siblings have all been in care England	Thirty-eight placements. Subject to secure order Placed in unregulated placement out of area Access to cannabis despite DoLS and 5 to 1 staff ratio	Pregnancy by male carer. Sexual abuse and grooming within placement whilst subject to DoL order
Child F, 2022	Stockport Safeguarding Children Partnership (2022), *Child Safeguarding Practice Review – Child F* Author: Katie Bates, Safeguarding Partnerships Manager	Child F: female, aged 17 Diagnosis of autistic spectrum disorder, poor executive functioning, OCD, Tourette's syndrome with both verbal and physical tics and anxiety England	Incident within out-of-home placement Multiple placements Subject to DoLS	Sexually exploited at the age of 12. Ongoing vulnerability led to her being subjected to DoLS and placed in care. Placement did not implement the DoLS measures as required. Child F was sexually assaulted whilst missing from care.

'Ruby', 2021	The Bradford Partnership (2021), *Child Sexual Exploitation Thematic Child Safeguarding Practice Review* Author: Clare Hyde	Female: risk of CSE aged 13. In care aged 15 Physical chromosomal condition, learning disability and ADHD. Mental health. England	Part of wider investigation into child sexual abuse gangs in Bradford. Report: 5 children, 2 known to be disabled 'Ruby' had 14 placements including secure	This is included as 'Ruby' was in care home at the time of sexual exploitation by gangs and was disabled. Previous specialist placement. Self-harm. Missing Sexual exploitation incl. rape and abduction Out-of-area placement
'Emily', 2024	Enfield Safeguarding Children Partnership (2024), *Local Child Safeguarding Practice Review Regarding Emily* Author: Josie Collier	Female: aged 16 at time of incident In care from age 4 Foster placement breakdown age 15 Autism, global developmental delay, and ADHD England	Hospital admissions and two additional residential placements Sectioned under MHS aged 13 Police involvement: multiple callouts to residential home DoL orders in place from aged 15 years, 8 months. Hospital restraint, but not in placement. History of running away	Restrained: police custody. Went missing from residential placement despite DoL order in place Groomed online. Raped and injected with cocaine
'Beth', 2019	*Serious Incident Investigation Report Secretary of State Case Review into Beth* (October 2019)	Female: aged 17 when case was made public through parent advocacy Autism	'Beth' was hospitalised aged 12. Learns self-harm and to tie ligatures Secluded within placement aged 16. Challenging behaviour – 'a failure to	Note: this is not a serious case review, but a government report based on a review

		England	recognise the communication of unmet needs expressed by such behaviours and furthermore, normalised profound restrictive practices	Restrictive practices Psychological harm. Restriction, stripped naked, and sedated Lack of provision and early coordination of services
'Isabelle', 2020	Angus Child Protection Committee Significant Case Review *'Isabelle', Executive Summary*	'Isabelle': female, died by suicide age 17 Autism diagnosis Scotland	Autism – diagnosis 3 years prior to death ADHD just before age 16 Multiple placements including secure and return to secure due to lack of suitable placement Out-of-area placements Drug use and potential sexual exploitation considered but not explored Advocate support to present voice Move out of secure, but not in education or working. Assessment process for independent living, went missing from care placement. Found – completed suicide	Child protection concerns – possible exploitation? Systemic issues identified by report writers: communication, information sharing, transition planning, understanding of autism, individual needs and presentation
Young Person D, 2024	City of Edinburgh Child Protection Committee, *Learning Review: Young*	Young male: age 19, died by suspected accidental overdose ADHD, autism	ADHD diagnosis age 6 Autism later in life Drug and alcohol misuse, mental health concerns	Focus of learning review on young people and adult services during time period from homelessness to death

	Person D, Executive Summary of Learning	Scotland	Family fled domestic abuse Previously subject to Compulsory Supervision Order (age 12?) but unclear as to how long for – not covered within learning review Offending behaviour. Subject to Community Payback Order Homelessness	Issue of transition between children and adult services Not in residential care

Appendix C – Critical Appraisal Skills Programme quality checklist

Criteria included:

- Was there a clear statement of the aims of the research?
- Was a qualitative methodology appropriate?
- Was the research design appropriate to address the aims of the research?
- Was the recruitment strategy appropriate to the aims of the research?
- Was the data collected in a way that addressed the research issue?
- Was the relationship between researcher and participants adequately considered?
- Were ethical issues taken into consideration?
- Was the data analysis sufficiently rigorous?
- Is there a clear statement of findings?
- How valuable is the research?