Executive summary

Abuse in residential care institutions for disabled children and young people

Report for the Scottish Child Abuse Inquiry

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Introduction

This review of UK and international evidence on the abuse of disabled children and young people 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.

Beginning in April 2025, Phase 9 of SCAI's investigations concerns the provision of residential care in establishments for children and young people with long-term healthcare needs, additional support needs, and disabilities. In view of the limited number of studies that have investigated the question of abuse of disabled children in residential care in Scotland, evidence is included from across the UK and internationally to share wider learning.

Context

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. The UNCRC outlines children's rights to protection, participation, and provision, which are interlinked, interdependent, and indivisible.

The United Nations notes that disabled children in institutions are at an especially heightened risk of violence, abuse, and exploitation. Disabled children and young people 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.

Scope and parameters of the review

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?

Given some of the definitional challenges concerning disability and residential settings, it is important to provide clarification of the definitions used within the review.

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.

Disability – We use the definition of disability as it appears in the Equality Act 2010, as this consolidates UK discrimination law.

Perpetrator of abuse – This review includes all perpetrators of abuse within residential settings, including children who abuse other children.

Residential settings were defined as specialist institutions designated for disabled children or children who have additional health or support needs, and where the child has been placed in such an institution predominantly on the basis of being disabled or requiring additional, associated support.

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), (Scottish) significant case reviews (SSCRs), learning reviews, serious case reviews (SCRs), practice reviews, independent reviews, or inquiry reports across the UK.[1]

- Relevant international inquiries and commissions within countries aligned to a similar cultural context 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. Papers and reports were required to have been published no earlier than 2014 and to relate to disabled children and young people up to the age of 18.

Overall, the review found a paucity of research evidence examining the abuse of disabled children in institutions, although material does evidence systemic patterns of abuse and failures across the UK and within the international context. It is 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, in recent times. However, extensive searches 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 of disabled children and learning that would support prevention and improve responses and recovery.

Findings

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

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

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

settings, and therefore their disability status will not be recorded. There are also multiple definitional challenges regarding the nature of residential settings, and significant challenges with missing data due to disabled children residing in unregistered settings. These issues with definitions and recognition of disability present problems to accurate numbers being established. The general 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, in other provinces of the UK, and on an international scale.

Only three academic journal articles fully met the inclusion criteria of the review, and they provide some, albeit very limited, evidence on the extent of abuse. Euser and colleagues' (2016) study examined the prevalence of sexual abuse of children with intellectual disability in foster and residential care in the Netherlands. Findings suggest 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), also from the Netherlands, examined the prevalence of child sexual abuse within care, comparing those with and without intellectual disability. They 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 harm caused by other children. Both studies focused on intellectual disability and sexual abuse, and both have limitations in terms of data collection being based on staff reporting of abuses.

Drawing attention to the evidence on the nature of abuse, an article by Hoffmann and colleagues (2020) on childhood experiences of hospitalisation identified emotional, sexual, and physical abuse, and neglect within psychiatric settings, with physical harm being the most prevalent.

Analysis undertaken of the sample of individual cases within significant/serious or safeguarding practice reviews demonstrates a varied picture of the nature of abuse of disabled children in residential care settings. There were two cases of abuse by other children, and one case of sexual abuse by a male carer. Restraint as a form of abuse was present in three of the case reviews, with both chemical (sedation) and physical restraint as well as dehumanising behaviour of staff (the child being stripped naked) in one case. It is significant that of the 11 individual cases analysed, seven involved significant harm outside the placement. This included three cases that resulted in the death of the child, although not by the hand of their carers within the residential placement. These are included in this report because they underline an issue that emerged from the data concerning the vulnerabilities of disabled children within residential settings to exploitation outside the placement and the institution's failure to protect children in its care.

The New Zealand studies (Royal Commission of Inquiry, 2024) reference abuse pre-1999 of disabled people who were in residential care in childhood. These studies gathered narratives of the lived experiences of disabled survivors of abuse, 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. In the UK, the Child Safeguarding Practice Review (2022, 2023) (hereafter Hesley Review) of 108 children abused within the three residential settings operated by the Hesley Group found that children had experienced systematic and sustained abuse that included physical abuse and violence from staff and other resident children; emotional abuse, cruelty and neglect; sexual harm from the breaching of boundaries between staff and children; poor quality of care; and children's medical needs not being met. Evidence also revealed that medication was misused, maladministered, and disposed of inappropriately. Children experienced repeated and dangerous physical restraint, were deprived of their liberty, and were subjected to physical abuse as a form of discipline. Bullying and taunting were a feature of life in the settings. Children were also denied access to their communication method, rendering them voiceless and powerless.

There is strong evidence within the individual case reviews and reports, and within the Hesley Review, that restraint and the management of behaviours through seclusion have been used routinely within some settings, with serious harms to disabled children's mental, emotional, and potentially physical health. A further issue particularly pertinent to meeting the needs of disabled children in care settings 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 a person's own, and/or others' protection and safety but this must be justified under law. Roe (2023) identifies in particular that disabled children form a distinct group, with DoLS applications being made on the basis of needing support/supervision for children with learning and physical disabilities. The fact that a disabled child or young person is deprived of their liberty in order 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.

What are the risk factors for disabled children?

The available evidence points to a range of risk factors both within and outwith the residential settings. These include:

Risk factors prior to placement within a residential setting

- A long history of unmet needs prior to placement in residential care, with children often experiencing high levels of multiple placements and educational disruption. There was evidence to show 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

- A pattern of placements breaking down outside of formal processes leading to crises' rather than a planned approach and a thorough review of a child's and family's needs

- Multiple placement moves that destabilised children, limiting their abilities and opportunities to develop trusting relationships that could foster security and stability

- A lack of appropriate placements which impacts on risk and planning being appropriately managed prior to placement in a residential setting

- A lack of resources and adequate provision to meet the needs of this group of children, which directly impacts on the availability of appropriate residential placements and placements close to home. Inappropriate placements can lead to increased risk of harm when staffing and training are inadequate and the service provision is not appropriate to meet the needs of the child

- A placement at a considerable distance from a child's home was often seen as the only viable option, exacerbating a closed culture[2] and denying disabled children their right to a family life. A report by the Care Inspectorate (2022) specifically raised concerns about the use of long-distance and, in particular, cross-border (from other UK jurisdictions) placement of children

The evidence collated from Hesley and the individual child abuse reviews or reports highlights that when decisions are made about the placement of disabled children, safeguarding considerations are not always fully risk-assessed and planned for. This includes whether there are 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. This can significantly increase levels of behaviour described as 'challenging', anxiety, trauma, and unsafe environments.

Risk factors within the institutional setting

Multiple risk factors were identified, including:

- The inability of institutions to understand and meet the basic human needs of disabled children placed within their care, including their intersectional needs. This was often linked to poor training, supervision, and a failure to follow the care plans of individual children.

- Within three SCRs where deprivation of liberty (DoL) orders were in place to protect the child, one child was groomed and became pregnant by a carer within the placement, one child was drugged and raped by someone she met online, and the third absconded and became pregnant. 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.

- Research points to real concerns as to the impact of the use of restraint and seclusion. The Children and Young People's Commissioner Scotland (2018) highlights the issues of sporadic and patchy understanding and

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

implementation of conventions and law across Scotland regarding the seclusion and restraint of children. The Children's Commissioner for England's (2019) report, which detailed the experiences of autistic children and young people, and children with learning disabilities who were staying in mental health hospitals, spoke of staff using physically restrictive measures as a matter of routine. The report also found examples of the use of chemical restraint and long-term segregation and seclusion. Previous studies, including Pinney (2017), likewise raise concerns around the appropriate use of chemical restraint, reporting that two-thirds of autistic children and young people and children with learning disabilities 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). Calabrese and colleagues (2024) analysed data collected over years of recorded incidences of restraint (chemical and physical) for all children, and found that autistic children were 'significantly more likely' to be restrained 'involuntarily'. However, 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.

Risk associated with living with others within settings

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. 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.

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. A more granular and 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. It is important to take a considered, trauma-informed approach to disabled children who commit abuse of other children. 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.

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. The issue of appropriate and explicit sex education and support with healthy relationships is also evident in the SCRs. There is a dearth of evidence to support practice and policy development in this area.

Organisational structure and management

Organisational factors, in particular management and supervision within settings, are another area of concern. Risk factors included:

- The disparity between the detail of care and management of a setting recorded on paper versus the reality
- Provision of full packages of support for children (education and care within one setting). When children live and are educated in the same place and have some of the same staff across these two settings, there are fewer opportunities for any signs of abuse to be raised. This closed setting means there is little external challenge to poor practice from outside agencies or opportunities for staff to share concerns they may have with outside professionals
- Evidence that staff are unaware of policies relating to safeguarding and whistleblowing or did not actively use them
- Closed settings facilitating a culture whereby when staff raise concerns, senior managers are able to minimise or ignore them. The Children's Commissioner for England (2019) raised concerns about accountability within mental health hospitals given the closed-off nature of these settings (2019).

Staff recruitment, training, and workforce issues

There was evidence of staff recruitment and retention issues across the data, leading to concerns that the children were not 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.

It is also important to recognise the significant impact staff turnover has on disabled children's daily lives. This might include not 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. Recommendations from the Hesley Review included that the status and pay of staff working in residential settings needed to be improved urgently.

The Hesley Review also 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 and to children's and disabled people's rights is also vital.

Power and 'voice' of disabled children within residential settings

Within the available evidence, disabled children had a clear lack of power, control, and means to 'voice' fear or harm, be seen, and seek help. The Hesley Review also starkly illustrated the lack of power or control for this group of children, and a lack of 'voice' in their everyday lives and in decisions taken about their care. Within the case reviews, there is also little evidence of children being engaged in decision-making about changes of placement.

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. 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.

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 children to disclose. Unmet communication needs was a significant feature of 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.

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).

It is important to also note the significance placed on defining some disabled 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).

Risk associated with inadequate external monitoring, scrutiny, and national policies

The evidence points to challenges with external monitoring, scrutiny, and national policies which should provide robust protective measures for disabled children in residential settings. Once more the evidence illustrates a litany of failures which increases the risk of abuse of disabled children. These included:

- Poor communication and cooperation between agencies
- Communication issues between the local authorities who fund places for children and the hosting local authorities

- A lack of decisive action when outside agencies and even national regulatory bodies became aware of issues of concern, meaning that potential or actual harm continued

- 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.

- The Hesley Review and other 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.

- Fragmentation of information and responsibilities across multiple teams meant oversight of the children was lost, with the result that adequate monitoring of the placement was missing and any concerns about possible quality or safety of a child's care were not identified. Children become lost in the system.

- 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.

- The Hesley Review also brought into sharp focus how residential care provision for disabled children operates within a complex maze of commissioning, delivery, and accountability that impacts the ability to oversee the quality of provision and care effectively. Similarly, the reports from the Independent Care Review in Scotland (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 settings, and they all recommend substantial revision.

In addition to the systemic failings both within and outwith settings identified above, there are 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, although these risks, we would argue, are not inevitable if service provision is adapted and adequately meets a child’s needs.

Miller and Brown (2014) highlight that the risks may increase for disabled children for several reasons. These include being alone with members of staff for intimate care needs, the potential for over-medication, poor feeding and toileting arrangements, issues around the management of ‘challenging’ behaviour, and limited access to appropriate education, stimulation, information, and emotional support. 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.

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. In such an absence, it is important to reiterate the learning from other sources investigating failures to protect and listen to children. It is likely that if the recommendations from the reviews, investigations, and inquiries were implemented fully then more disabled children would be protected and abuse prevented.

Prevention from going into residential settings through early family support and community provision

Much international literature identified within this review focuses on calling for the full deinstitutionalisation of disabled children. Many disabled children are placed in institutions in the UK because there is a lack of support for the family and within community provision, resulting in families reaching crisis point (Hesley Review, 2023). We argue that it should be possible to meet the needs of a child within the family home and that a 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.

The necessity of recognising a child's complex needs and of providing families with a high level of early support was highlighted in the Hesley Review. Similarly, Lenehan (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. Many families who contributed to the Hesley 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. 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. Within the Scottish context, Taylor and colleagues (2014) highlighted the lack of services for disabled children, which suggests that children are placed where their needs are not being met. Clearly, 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 (Franklin *et al.*, 2022).

Improving the provision in schools and preventing school breakdowns

Good educational provision and the prevention of school breakdowns can also avoid disabled children being placed in residential settings. Exclusion and breakdowns in school placements can lead to crisis within families and increase the need for residential placements. The evidence from Hesley and our analysis of the SCRs identified that disabled children often experience multiple educational placements, resulting in exclusion or 'managed moves' that were poorly planned. There is a clear need to improve the quality and range of educational provision and support available. The impact of multiple changes on a child's sense of security, safety, and behaviour appeared to be poorly understood.

Voice and agency of disabled children

The lack of voice, agency, and access to communication for disabled children in residential settings has been highlighted as a significant risk factor, and addressing this urgently is an important preventative action. Access to independent advocacy can support disabled children to communicate their needs, views, and feelings. Despite recommendations and commitments, independent advocacy services are rarely documented in SSCRs and SCRs.

Contact with parents/carers and family members

Supportive families and continued and facilitated contact with their disabled children are considered a major protective factor for disabled children in residential care (Hesley Review, 2023) and the most important mechanism to disrupt closed cultures. The role of parents as advocates to highlight issues was evident in four SCRs. This involved raising concerns not only about abuse but 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.

A named worker and staff consistency

The Lenehan Review (2017) recommended a key 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 named 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. Similarly, Ofsted (2024) found that the most reported contributor to children's stability in placements was the commitment and consistency of staff around the child. Yet we have already noted that workforce issues are endemic to supporting the development of these relationships and have highlighted the challenges this presents, in particular for children with communication needs who rely on staff knowing their communication method.

Outside scrutiny and not losing sight of the child

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 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.

A skilled and trained workforce

The evidence consistently indicates that there is a lack of investment in a skilled and trained workforce. 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. 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 health care needs and safeguarding of disabled children.

The Hesley Review 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 training of staff in settings regarding the appropriate use of restraint is mentioned in multiple sources. In addition, alternatives to restraint and a focus on using alternative measures to de-escalate or help children to regulate their emotions without harm must be considered.

The Hesley Review notes the need for an integrated strategy for workforce development and leadership, and clear standards and training for those working in and around residential care. Whilst this 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), 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.

Accessible sex and relationship education

Improved sex and relationship education, including information regarding sexuality and inappropriate sexual behaviour, was identified as a protective factor. 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

Proper planning, which fully assesses a child's needs, and whether a placement is appropriate for the child, and indeed children already placed there, should also lead to reduction in the harmful effects of placement breakdown. When moves are necessary, there needs to be improved communication between placements to ensure information is understood fully by the receiving placement. It is evident across the reviews of serious incidents that poor or incomplete information sharing made the transition from one placement to another a 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. 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 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 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

It is important to note that just because we do not have a vast array of detailed prevalence or statistical data on the abuse of disabled children, specifically within residential settings, this does not mean abuse is not happening.

There is a distinct lack of disabled children's voices within much of the literature identified. However, disabled children have unique, insightful, and important concerns and views which should be recognised, particularly if we are to improve policy and practice.

There has also been a lack of attention to the examination of 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.

The evidence presented in this review indicates that there may be situations where residential care should not have been the only option for disabled children. The evidence base is lacking in how such decisions are made and, importantly, how families can best be supported to prevent the need for disabled children to enter residential care.

The review found situations where staff and local authorities have been ignorant of children’s rights and the appropriate application of DoL orders. There is clearly an evidence gap surrounding the use and misuse of DoL orders, despite there supposedly being a robust and legal framework. In addition, we know little about the extent to which these offer greater protection to disabled children in residential care. The seriousness of the failings, 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.

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.

There is significant evidence of the harms caused to children through the inappropriate use of restraint. The evidence suggests that restraint is often unreported (Challenging Behaviour Foundation, 2020) and we do not have the full picture of current practice. 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. 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. 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.

In addition, there is a need for evidence on the effectiveness or otherwise of risk assessments and the factors impinging on effective risk assessment and management.

Whilst outside harm may not be at the immediate forefront of minds when discussing abuse of disabled children within residential settings, it is significant that seven of the SCRs examined were undertaken as a result of abuse outside the residential setting. Urgent attention needs to be given to understanding how these children were failed by the settings that were charged with protecting them.

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.

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/reviews of the abuse of children in care to make them inclusive of disabled children.

The above is not an exhaustive list of evidence gaps; however, addressing these would make a much-needed start to tackling the lack of evidence base from which to improve policy and practice.

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 SCRs 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.

Despite the narrow evidence base, there is consistency in data highlighting increased risks and evidence indicating where policy and practice need to change. 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.

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