Before the Purpose of Residential Child Care Is Defined

What is this children's homes workforce review at liberty to discover?

Critical narrative review

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Executive summary

This critical narrative review asks a simple question: what is the children's homes workforce review genuinely at liberty to discover? The Department for Education has commissioned a review that reaches well beyond training. It is being asked to help define the purpose of residential care, the knowledge and skills required of staff and managers, qualifications, professional development, career pathways and accountability. Its conclusions will inform new Department for Education-funded homes and may shape future standards. Yet the review began after government had already stated that residential care should be used for far fewer children and had committed itself to a substantial expansion of fostering. The central test is therefore whether the evidence remains capable of changing that direction. [1,2,3,110]

The historical evidence does not support treating residential care as a service that can be understood in isolation. Fostering, adoption, family support, youth justice, leaving care, secure care, supported accommodation, commissioning and regulation have repeatedly changed who enters residential care and what residential care is expected to do. Residential provision had already reduced dramatically by the end of the twentieth century. Utting warned in 1997 that residential child care had probably already shrunk below the level at which reasonable placement choice was possible. The House of Commons Health Committee concluded a year later that the reduction in residential capacity had gone too far. Narey returned to the question in 2016 and found very little scope for reducing reliance on children's homes further. Ofsted's own work has since shown repeated foster placement breakdown among many children who later enter children's homes. [29,31,63,78]

The review also challenges the way fostering and residential care are so often presented as opposites, rather than as different parts of the same care system. Fostering is the right form of care for many children and can provide relationships and belonging that last a lifetime. But modern fostering is also a publicly arranged, regulated, paid and increasingly commissioned service. Independent fostering agencies account for a substantial part of mainstream fostering. Fostering and residential care now operate within the same mixed economy, and policy decisions that expand one while reducing the other redistribute children, risk, capacity and cost across the same system. [75,103,110]

Residential child care cannot escape its history. The evidence from Moorfield, Pindown, North Wales, IICSA and other inquiries shows how harmful practices can become normal, how practices and assumptions can travel between people and organisations, and how difficult it can be for children and whistleblowers to be heard. But the same scrutiny must be applied to every setting in which the state arranges care. Foster care has its own history of abuse, professional failure and information that was known but not acted upon. Family does not guarantee safety and institution does not guarantee harm. The relevant questions are what adults do, what children experience, what is seen or missed, who is believed and whether somebody acts. [21,26,71,72,180,183]

Recent reform history raises a different problem. Governments choose which problems to investigate, which evidence to commission, which organisations and experts acquire authority and when evaluation occurs. That does not make evidence invalid, nor does it establish wrongdoing. It makes the framing and sequencing of evidence part of the inquiry. Regional Care Cooperatives, workforce reform and the idea that residential care should become smaller and more specialised have moved from review into implementation while important evaluation evidence is still developing. Evaluation during implementation is not the same as an independent test of whether the underlying premise should continue. [76,97,173]

Workforce reform therefore cannot sensibly be separated from the organisations, markets and regulatory arrangements within which the workforce operates. A higher qualification may be valuable, but professionalisation is more than a qualification. It also requires leadership, supervision, staffing stability, authority, institutional memory and the capacity to recognise and challenge harmful practice. No single therapeutic or pedagogical model can define good residential child care for every child. The model should follow the child, not the child the model. [1,126,128]

Relationships create another test. In parts of the care system, earlier safeguarding practice treated closeness, physical affection and contact after placement as professional risks. Current policy now promotes Staying Put, Staying Close and enduring relationships. That change is welcome, but it leaves difficult questions about who decides whether a relationship should continue, how unsafe relationships are identified, where professional responsibility ends and who carries risk and liability when a relationship crosses the boundary between a placement and private life. The most useful evidence may lie in the relationships that actually endured, those that the system ended, and those that became unsafe. [137,161,163,164,167,168]

The final test is the life the child goes on to live. “In care” does not describe a childhood. Placement labels do not tell us what happened before the placement, what happened within it, which relationships survived or what the adult later understood the experience to have meant. Those outcomes matter, but they do not tell us what the child experienced or what they carried into adulthood.

Before residential child care is redefined again, policy should follow the child through the whole journey and into the adult they become, test current assumptions against the longer history, and make the evidence, accountability and public cost visible. [139,140,141]

Source note: numbers in square brackets in the text refer to the numbered Sources and references list at the end of this review.

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Evidence can be selected as well as gathered

Governments decide which problems are investigated, which research is commissioned, which evidence is cited, which organisations are asked to interpret it and when evaluation takes place. Those choices are political.

The concern here is not that government has used evidence. It is whether evidence capable of supporting an existing direction has acquired greater policy authority than evidence capable of challenging it.

That question arises at several points in this review.

The workforce review creates one unusual alignment. The organisation chosen to examine whether workforce qualifications should change was selected partly because it was already associated with a new Level 6 qualification for that workforce. It was also selected because it had already developed a particular model of practice. [3,128]

Neither fact invalidates the review. Both make it particularly important that the review is capable of testing those approaches rather than beginning from them.

Evidence-led policy and policy-led evidence are not the same thing.

Political influence is inevitable. Political framing is inevitable. Political manipulation can arise when evidence, expertise, consultation or evaluation is used selectively to create the appearance that a predetermined political direction has been independently established by the evidence.

This review asks whether the process is sufficiently open, transparent and subject to independent challenge to identify and test that possibility.

The issue is therefore not whether the review is hearing a range of views.

It is whether what it hears is capable of changing the direction already stated by government.

If the evidence concludes that residential care should not become smaller, can the review say so?

If it concludes that some children should enter residential care earlier, can it say so?

If it finds that expanding fostering cannot reduce reliance on residential care to the extent government anticipates, can that change the policy?

If it concludes that residential care has several purposes rather than one purpose, can that shape what follows?

The question is therefore not whether the review team is listening to different views. It is whether the review remains at liberty to reach a conclusion that challenges a direction government had already established when the review began its work.

That is the question at the centre of this critical narrative review.

The existing literature gives us somewhere to begin. But the history we need to examine is wider than the history of children's homes.

Approach and scope

This is a critical narrative review rather than a systematic review. It does not claim to identify every publication about residential child care. It draws together legislation, government policy, parliamentary reports, public inquiries, inspection and regulatory evidence, official statistics, research and professional literature to examine how residential child care has been shaped over time and how that history bears upon the questions now being asked of its workforce.

My own experience spans five decades of children's social care and includes residential child care, fostering, community support, youth justice, social work, secure care and management. That experience inevitably influences the questions I ask. It does not determine the answers.

The review is principally concerned with England, while drawing on England and Wales where the historical legal framework or the organisation of secure care makes that necessary. Its purpose is not to argue that an earlier system was better, or that residential care should be preferred to fostering. It is to examine what successive reforms changed, what they achieved, what they displaced and what knowledge may have been lost or overlooked as one reform followed another.

The episodes considered here have therefore not been selected simply because something went wrong. They have been selected because they illuminate recurring questions about where children are cared for, how placement decisions are made, how professional knowledge develops, where authority sits, how services are regulated and what happens when policy changes one part of a connected system.

This review therefore tests two things. It tests the diagnosis that residential care should become smaller and more specialised while fostering expands. And it tests the method by which that diagnosis has moved from assumption, through review and into implementation. The question throughout is whether the evidence was ever genuinely capable of changing the direction of reform.

How the question is framed shapes the evidence

The Department for Education also commissioned a rapid evidence assessment, alongside stakeholder interviews, to gather and synthesise evidence on the knowledge and skills required within the children's homes workforce. [170]

A rapid evidence assessment can be rigorous within the terms it is given. But it is not neutral to the way the question is framed.

If a search begins with specialist or therapeutic residential care, it will find literature about specialist and therapeutic residential care. If the population is framed principally around children with the highest levels of complexity, it will privilege evidence about complex need. If professionalisation and graduate qualifications are foregrounded, it will find literature about professionalisation and qualifications.

If instead the starting question is which children cannot live safely within their families and what range of care they need, the evidence may look different.

An independently conducted evidence review is not necessarily an independently framed research question.

Who framed the question matters as much as who reviewed the evidence.

That is not a criticism of the researcher conducting the assessment. It is a methodological question about whether the evidence was asked to test the policy premise or to inform the development of a policy direction already established.

Children's social care is one system

This is not simply a history of residential care.

It is a history of children's social care, within which residential care, fostering, adoption, family support, youth justice, leaving care and later supported accommodation have repeatedly been reorganised, separated, combined and redefined.

Residential care and fostering are different parts of the same care system. Children move between them. Policy may expand one, reduce another or express a preference for one over the other, but decisions made in one part change what happens in another.

Adoption is different because it is intended to end that care journey for some children by creating a new legal family. For many children it does. For some it does not. Adoptions are not always successful. Some children return to care. Others continue to need substantial support after adoption.

Changes in youth justice altered which children entered residential care. Permanence planning and family finding changed which children remained in care. Specialist and contract fostering extended fostering to children who might previously have been cared for residentially. Leaving-care policy changed what happened to adolescents approaching adulthood. The development of 16-plus units, hostels, supported lodgings, training flats, foyers and later semi-independent provision created new boundaries between care, support and independence.

Those boundaries changed again when accommodation defined around support rather than care, already used outside children's-home registration for some older children, became a separately regulated category of supported accommodation in 2023.

Children's social care is a system of connected parts. Alter one part and the consequences appear somewhere else.

That is why the present decision to review residential child care separately from fostering matters. If government intends to expand fostering while using residential care for far fewer children, the evidence about both, including why placements succeed or break down and how children move between them, belongs within the same examination.

The history that follows therefore asks how successive governments have changed where children were cared for, who was responsible for them, what counted as care, what happened when children crossed the boundaries created around them and which forms of knowledge were valued or lost along the way.

Throughout the history of children's social care, we see, and children feel, the effects of political ideology.

Governments bring ideas about family, childhood, responsibility, professional authority, punishment, markets and the proper role of the state. Those ideas influence what problems are noticed, which solutions become possible, what provision is expanded or reduced, what is measured and which forms of care acquire political favour.

The post-war creation of specialist Children's Departments reflected one understanding of state responsibility. Seebohm reflected another understanding of integration and the family. The 1969 reforms attempted to bring welfare and offending closer together. Later youth-justice policy separated them again. Permanence policy strengthened the preference for substitute family life. New Labour placed increasing faith in structural reform, performance indicators, new providers and alternative professional routes. The Cameron years changed the language inherited from *Every Child Matters*, accelerated adoption and strengthened the emphasis on permanence and achievement. Successive governments increasingly relied upon markets to provide fostering and residential capacity. The current reform again places strong emphasis on family care, regional commissioning, workforce redesign and a smaller, more specialised residential sector.

These are not simply technical choices. They reflect political judgements about what childhood should look like, where children should live, who should care for them, where responsibility should sit and what the state is prepared to spend.

Children experience those judgements as placements, moves, relationships and losses. A change in political philosophy can become a closed home. A permanence target can become a faster adoption decision. A preference for fostering can become another foster placement. A market reform can determine whether a suitable placement exists locally.

Political ideology becomes practice long before a child knows the thinking that produced it, and sometimes they never know it at all. Without that knowledge, the adult they become may never fully understand why their childhood unfolded as it did.

Follow the child, not the category.

The system has already been repeatedly reorganised

The modern history of children's social care does not begin with the decline of children's homes in the 1970s.

The Children and Young Persons Act 1933 already placed care, protection, parental control and offending within overlapping legal arrangements. Juvenile courts could deal with children who had offended, but

children considered in need of care or protection, or beyond parental control, could also enter the approved-school system. [4]

The same legislation allowed a child to be committed to a fit person. A local authority could be that fit person and could board the child out with foster parents.

Different routes into state intervention were therefore never as separate as later accounts sometimes suggest. A child who offended might also be neglected. A child regarded as beyond parental control might also need protection. The difficulty of separating care, protection, education, treatment and control was already present.

The Children Act 1948, passed under Clement Attlee's government following the Curtis Committee, established a much clearer specialist child-care structure. [5,6]

Local authorities were required to establish Children's Committees, appoint Children's Officers and develop Children's Departments.

Residential care and boarding out, what we would now call fostering, sat within the same specialist child-care responsibility.

That matters because fostering was not introduced decades later as an alternative to an essentially residential system. Both have a long history. What changed was the balance between them and the children expected to use each.

The 1948 Act also recognised that responsibility did not necessarily disappear when a young person left care. It provided for aftercare, including the duty to advise and befriend certain young people, hostel accommodation and financial support for education and training.

Aftercare was therefore part of the post-war conception of child care.

There was an important principle within the provision for hostels. They did not have to accommodate only young people who had been in care. Parliament was explicit about why. Young people who had been in care should not be segregated or marked out as a separate group. The intention was to avoid the stigma that could follow them after care by enabling them to live alongside young people who had not been in care.

More than seventy years later, that is worth remembering.

Separation, relationships and the beginnings of a therapeutic understanding

The Second World War produced another body of knowledge that would profoundly influence the way separated children were understood.

Evacuation brought questions about separation, substitute care and emotional development into sharp focus.

"Donald Winnicott and Clare Britton worked with children who had been evacuated but had been unable to settle with the families they were sent to live with." [7]

Their work led to an important proposition.

The residential setting itself could form part of the treatment.

Their 1947 paper, *Residential Management as Treatment for Difficult Children*, did not treat residential workers simply as people providing accommodation around treatment delivered somewhere else.

Everyday care mattered.

Relationships mattered.

The reliability of adults mattered.

The organisation of the environment mattered.

And disruption within the adult group could affect the children living within it.

Winnicott and Britton were therefore writing about the therapeutic possibilities of everyday residential life decades before present-day services began describing themselves as trauma informed. [7]

John Bowlby developed another enormously influential strand of thinking. [8,9]

His work on separation, maternal care and later attachment theory drew attention to the importance of continuing relationships and to what could happen when young children experienced loss, separation or institutional care without reliable substitute relationships.

Bowlby's work became hugely influential across child care, fostering, adoption and later social work.

But its history also provides a warning.

Complex ideas can become simplified as they travel.

Bowlby's early work became closely associated with the language of maternal deprivation and was sometimes reduced to a much more categorical proposition about the necessity of continuous maternal care than later attachment theory would support.

The broader development of attachment theory moved towards a more complex understanding of the importance of familiar, responsive and reliable caregivers, and of relationships that endure over time. What current policy describes as enduring relationships therefore has a much longer intellectual and practice history.

The distinction matters.

Ideas do not simply travel. They can change as they travel.

A complex theory can become a slogan.

A qualified proposition can become a professional certainty.

A valuable insight can become the explanation applied to every child.

Attachment theory nevertheless contributed something fundamental to children's social care.

Relationships matter.

Loss matters.

Separation matters.

Repeated disruption matters.

The availability and reliability of familiar adults matter.

Those ideas would continue to influence fostering, adoption and residential care and would later intersect with developmental psychology, neuroscience and the growing literature on trauma.

The language changed.

Some of the questions did not.

Mother and baby homes belonged to the same wider history

Alongside the new Children's Departments was another residential system.

Mother and baby homes operated across England and Wales through the 1950s, 1960s and into the 1970s. Some were publicly run. Many were operated by religious or voluntary organisations.

Young, unmarried women and girls could be sent away during pregnancy, give birth and remain for a period afterwards. For many, the home formed part of a route through which their babies subsequently went to foster carers and prospective adopters.

The later Joint Committee on Human Rights inquiry concluded that many women did not experience adoption as a meaningful choice. Social stigma, family pressure, institutional practices and inadequate alternatives shaped what happened to mothers and their babies. [80]

This history belongs within children's social care because adoption, residential provision, family policy and state intervention were developing alongside one another. Government and other agencies were deciding which children should be cared for away from their families, which should be boarded out, which babies should enter new permanent families and what help should be available to prevent separation in the first place.

Mother and baby homes progressively disappeared as a mainstream response.

The consequences did not.

Decades later, Parliament returned to the experiences of the women and children who had lived through them.

Buildings close.

Administrative categories disappear.

The people who lived through them carry the history forward.

That is one reason institutional memory matters.

Prevention, Seebohm and the loss of specialist Children's Departments

By the 1960s, policy was moving towards greater support for children within their own families.

The Children and Young Persons Act 1963 strengthened the ability of local authorities to provide help intended to prevent children coming into care. [10]

Prevention was therefore not discovered by current family-help reform. It has a much longer history.

Then came Seebohm.

The 1968 Seebohm Report examined the organisation of local-authority personal social services. [11,155]

Its central insight remains persuasive.

Families could find themselves dealing with separate children's, welfare, health, housing and other services, each seeing only part of a larger situation.

Parliamentary discussion captured the principle simply:

"The family is one."

A child's circumstances could not always be separated from poverty, housing, parental illness, disability, relationships and other pressures within the household.

The Local Authority Social Services Act 1970 brought Children's Departments and other welfare services into larger social services departments. [14]

Integration addressed one problem.

It created another.

Where would specialist knowledge about children sit within the new structure?

Separate Children's Departments disappeared. Generic social work developed. Concerns followed about whether enough specialist child-care knowledge would survive.

That tension has appeared repeatedly in later reform.

A legitimate problem can be identified.

The principle behind reform can be sound.

The structure chosen to deliver it can still create another problem.

Reform can solve one problem while creating another.

There is a striking pattern here.

In 1948 government deliberately created specialist child-care structures.

Little more than twenty years later those structures were dismantled in favour of generic social services.

Over the decades that followed, specialist services had to be recreated around particular parts of children's lives.

Family-placement teams emerged.

Adoption teams.

Fostering teams.

Child-protection specialists.

Youth-justice teams.

Leaving-care teams.

Residential specialists.

The question is not whether specialisation is always preferable to integration.

It is what knowledge was lost in each reorganisation, and why the system repeatedly had to recreate specialist knowledge after dispersing it.

The 1969 Act and the community-home system

At almost the same time that specialist Children's Departments were being absorbed into generic social services, another major merger was taking place.

The Children and Young Persons Act 1969 sought to break down the institutional and legal divisions between children regarded as deprived and children regarded as delinquent. [12,13]

There was a clear logic to the principle.

A child who offended might also have experienced neglect, poverty, abuse, family breakdown or educational failure.

A child appearing before a court could also be a child who needed care.

But the scale of the change was considerable.

Approved schools, remand homes, children's homes and hostels were brought together within the new community-home system. The new framework brought very different types of residential care under one system.

At one end were small local children's homes and the family-group-home tradition.

At another were observation and assessment centres, secure accommodation and community homes with education on the premises, many of them former approved schools.

The legislation deliberately created one legal category while recognising that the establishments within it would remain very different.

The children were different too.

Changing the institutional category did not remove the needs, behaviour or risks for which the previous services had existed.

Approved-school orders disappeared.

Young people did not stop offending.

Remand homes changed.

Children did not stop requiring secure or highly supervised care.

Residential nurseries disappeared.

Older children still needed somewhere to live.

The 1969 legislation also introduced intermediate treatment through supervision orders. It was intended to provide a constructive alternative to removing children from their communities and placing them in more institutional forms of care or control. [19]

Again, the principle had merit.

If a child could safely remain within their family and community with appropriate help, removal should not be the consequence of a lack of alternatives.

But intermediate treatment also changed the population entering residential care.

Children successfully diverted through community intervention did not enter residential homes.

Those who did enter increasingly included children whose difficulties had not been resolved elsewhere.

Structural reform redistributed responsibility. It did not make the underlying need disappear.

At the same time, fostering and adoption increasingly became the preferred response for younger children.

That changed who remained in residential care.

Residential services increasingly cared for older children and those whose needs could not be met elsewhere.

The workforce changed in response.

So did expectations about what residential staff should be able to manage.

This is an important finding in the historical literature because it shows that placement policy does not simply alter where children live.

When policy changes who is able to enter residential care, it changes what residential care is expected to do. It does not determine which children need residential care, or which do not.

Drift, permanence and family finding

By the early 1970s another problem had become increasingly visible.

Children could remain in care for years without a sufficiently clear long-term plan.

Jane Rowe and Lydia Lambert's *Children Who Wait* became part of a growing concern about drift and the need to find permanent substitute families for children who could not safely return home. [16]

The Children Act 1975 and Adoption Act 1976 formed part of the changing policy response. [17,18]

Permanence planning became increasingly influential.

Family finding became a distinct professional activity.

Specialist family-placement services developed around fostering and adoption.

There was another sound principle here.

Children should not spend childhood waiting while adults avoided difficult decisions about whether they could return home or needed another permanent family.

But permanence policy also changed the care population.

When more younger children left care through adoption, or were placed in long-term foster families, the population remaining in residential care changed again.

This is why it is misleading to look at the later population of children's homes and assume it demonstrates what residential care had always been for.

Policy had progressively changed who reached it.

Specialist and contract fostering

Fostering itself was changing.

It was not simply expanding numerically.

Its purpose was being extended.

The Kent Family Placement Project in the 1970s was one influential development. It challenged the assumption that adolescents with significant difficulties necessarily required residential care. [20]

Foster carers were recruited and trained for the work and paid a professional fee. Agreements were made around what the placement was intended to achieve.

For some children it offered a family placement that might not otherwise have been available.

It also helped establish approaches that, by the late 1970s and early 1980s, were developing into specialist, professional and contract fostering.

Again, the point is not that this was wrong.

It is that every successful extension of fostering changed the group of children remaining in residential care.

There was another development.

As fostering became increasingly professionalised and increasingly fee-paid, it also expanded beyond local-authority fostering services.

Independent fostering agencies became an increasingly important part of the care system.

This matters because the development of a mixed economy was not confined to children's homes. Local authorities increasingly purchased foster placements from independent organisations as well as purchasing residential placements from independent providers.

By the end of the twentieth century, independent fostering agencies had become an established part of fostering provision.

The history of market development in children's social care therefore occurred on both sides of the fostering and residential boundary.

Fostering cannot escape its history

Fostering should not escape its own history simply because it takes place within a family home.

Boarding out had long involved payment. During the second half of the twentieth century, fostering progressively became a more professionalised service, bringing important gains in training, support and the ability to care for children whose needs might previously have been considered beyond family placement.

Specialist and contract fostering were part of that development.

So were fees.

Allowances.

Formal assessment.

Training.

Supervision.

And later the growth of independent fostering agencies.

The foster home remained a family home.

It also became a place from which a publicly funded service was delivered.

For some carers, fostering became their principal occupation. Some households cared for several unrelated children. Some specialised in particular needs or age groups. Some worked through independent agencies competing for local-authority placements.

The domestic setting remained. The system around it changed.

Policy has not always acknowledged that clearly enough.

Fostering continues to be presented through the language of family life, belonging and normality, often in contrast to residential care. Government now uses the language of the "stable, loving home" when describing what children need from care.

A good foster family can provide intimate family relationships, shared family life and belonging. But fostering is also a state-arranged intervention.

Carers are assessed and approved.

They are paid.

Fostering services are regulated.

Placements are commissioned.

Children are moved.

Placements end.

Agencies compete for business.

Private companies own fostering agencies.

The existence of family relationships does not remove the service, regulatory and economic structures around them.

Nor does payment make those relationships less real.

The problem arises when the language of family makes fostering appear outside the economics and organisation of children's social care.

Residential care can then be portrayed as a service and fostering as a family; residential care as expensive and fostering as a stable, loving home; residential care as an intervention and fostering as ordinary family life.

Those are not equivalent comparisons.

The fair comparison is between two forms of publicly arranged care, each capable of providing important relationships, each capable of failing, and each shaped by the organisations, funding, regulation and commissioning arrangements around it.

For many children, fostering is exactly the right form of care.

That does not mean it is right for every child, or that another foster placement is preferable to residential care after previous family placements have repeatedly broken down.

The historical development has also made the dual character of fostering increasingly visible. A household can remain a family while also forming part of the infrastructure through which the state meets its statutory responsibilities to children.

By March 2025, independent fostering agencies accounted for around 45 per cent of mainstream fostering households in England. Ofsted recorded 339 independent fostering agencies, most privately owned. [103]

Government is therefore not proposing a simple movement away from commercial residential care towards family care.

The choice is not between family and market. The market now runs through both.

This does not make fostering wrong.

It makes scrutiny necessary.

Residential care has been required, rightly, to confront its institutional, professional and commercial history.

Fostering should be examined with the same seriousness.

By the end of the 1970s, children's social care was already being pulled in several directions at once. Specialist Children's Departments had disappeared into generic social services. Very different residential

establishments had been brought under one community-home umbrella. Intermediate treatment was intended to prevent unnecessary removal. Permanence planning and family finding sought to prevent drift. Adoption was being reformed. Specialist fostering was extending family placement to adolescents previously thought difficult to foster.

These were not independent developments. They changed one another.

Residential care had already been substantially reduced

The long-term direction of policy is clear.

In 1976, around 40 per cent of children in care were living in residential accommodation and around one third were fostered. By 1996, approximately 12 per cent were living in residential care and around 65 per cent were fostered. [31]

The major reduction in residential care had therefore already happened before the end of the twentieth century.

That needs to be separated from another change that followed.

Who provided the residential care that remained also changed.

In March 1996, almost three quarters of children's homes were still run by local authorities. Over the following decade the balance shifted rapidly towards private provision.

These are different developments.

Residential care was reduced while fostering became the dominant form of care. The ownership of much of the residential provision that remained then shifted away from local authorities.

That distinction matters.

The later growth of the private residential market should not be confused with an unchecked expansion of residential care itself.

Residential care had already become a much smaller part of provision.

What expanded later was private ownership within the residential sector that remained.

The history therefore raises a different question: why, after residential care had already become a much smaller part of the care system, is government now seeking to reduce it further?

Earlier reviews did not assume that fostering could replace residential care

The literature becomes particularly important here.

Sir William Utting warned in 1997 that residential child care had reduced below the level at which reasonable placement choice could always be provided. [29]

The House of Commons Health Committee reached an even clearer conclusion in 1998. [31]

It found that:

"the reduction in residential home capacity has gone too far."

The Committee considered fostering and residential care together. It rejected the assumption that fostering could continue expanding until residential care became unnecessary.

There would continue to be children, particularly older children, for whom residential care was the better option.

The Committee also recognised something that remains important now.

Choice requires some spare capacity.

A system in which every bed must always be occupied may look efficient, but it leaves little room to decide which placement is right for the child who needs one.

Spare capacity is not waste. In a care system it is what makes choice possible.

The significance of the 1998 report is not that its conclusions must remain unchanged forever.

It is that the question government is now asking has been asked before.

A policy that reaches a different conclusion should therefore be able to show what evidence has changed.

The mixed economy was not preserved

The reduction in residential provision also changed how capacity was maintained.

There was nothing inherently wrong with local authorities, voluntary organisations and independent providers operating alongside one another.

Different organisations contributed different things.

Public provision retained direct operational experience and capacity.

Voluntary organisations brought their own histories and purposes.

Independent providers could develop services where need was not being met.

The mistake was not creating a mixed economy. The mistake was failing to preserve one.

As local authorities withdrew from their own residential provision, they increasingly moved from maintaining capacity themselves to purchasing placements as they were needed.

The immediate financial attraction was understandable. A local-authority home carried staffing, property and running costs whether every bed was occupied or not. Purchasing a placement only when required transferred much of that risk elsewhere.

But the need for capacity remained.

The empty bed risk had been transferred, not removed.

A parallel development occurred in fostering. Local authorities retained their own fostering services but increasingly purchased placements through independent fostering agencies.

By 2022, the Competition and Markets Authority was describing a market in which local authorities struggled to find suitable residential and fostering placements, particularly for children with more complex needs. It identified geographic mismatch, weak purchasing power and high profits and debt within parts of the market. [75]

Its conclusion returned to something earlier literature had already recognised.

The issue was not simply how many places existed.

It was whether the right provision existed in the right place for the child who needed it.

The mixed economy required somebody to protect the mix.

Markets do not preserve a mixed economy by themselves.

The movement towards purchaser-provider arrangements and independent provision began before Tony Blair became Prime Minister in 1997. Blair did not create the children's social-care market. But his approach to public-service reform relied increasingly on changing structures, bringing in alternative providers, creating competition, setting stronger performance indicators and moving authority elsewhere.

Those choices helped embed marketisation.

If public provision was allowed to contract, where was the safeguard intended to preserve sufficient public capacity? Who monitored whether voluntary and smaller independent provision could remain viable? Who watched concentration of ownership? Who retained responsibility for strategic capacity when local authorities moved from operating services to purchasing placements?

Choice requires capacity. Competition requires more than one viable provider. A mixed economy requires the public, voluntary and independent parts of the system to remain sufficiently strong that none becomes the only realistic source of provision.

Government is now trying to control some of the consequences of a market the Competition and Markets Authority described as dysfunctional. That is not the same as restoring the mixed economy that was allowed to disappear.

Power to reform should not be power to avoid accountability for the consequences of reform.

The history matters to both fostering and residential care. Different routes produced different markets, but both now sit inside the same publicly funded care system.

Expanding fostering while reducing residential care will therefore do more than redistribute placements. It will change which children each part of the system is expected to care for and where the consequences of those decisions land.

Residential child care cannot escape its history

The children entering residential care during these decades did not arrive without histories of their own.

Many had already experienced neglect, abuse, bereavement, family breakdown, poverty, disrupted education, offending, rejection or repeated moves.

Residential care could help children with those experiences.

It could also make them worse.

Where children experienced harsh punishment, humiliation, excessive control, isolation, violence, abuse or relationships that broke down again, the harm did not replace what had happened before they entered care.

It was added to it.

That matters when we look back at children later described as particularly troubled, difficult or challenging.

Some brought profound needs with them.

But what happened after they entered care could compound those needs, increasing fear, anger, mistrust and difficulty forming relationships.

Poor care added another layer of harm.

By the mid-1970s, the community-home system was still relatively new and the boundaries around discipline, punishment and control remained unsettled.

The Community Homes Regulations 1972 emphasised good personal and professional relationships but also allowed local authorities to authorise additional measures of control.

Residential staff were expected to care for children and control behaviour, but without sufficiently clear guidance about where legitimate authority ended and unacceptable practice began.

In that gap, practices that had been accepted or overlooked in approved schools travelled with people into the new community-home system.

I entered children's social care in 1976, while these debates were still live. I remember a workforce expected to care for children and exercise control while the boundaries of acceptable practice remained unresolved. The documentary record shows that this uncertainty was real.

The 1977 Hytner Inquiry into Moorfield Observation and Assessment Centre provides direct evidence of what happened during this transition.

It was not simply an inquiry into isolated allegations. Its terms of reference included alleged ill-treatment, the management and day-to-day running of the centre, possible breaches of the Community Homes Regulations 1972, staff relationships with children, complaints and disciplinary procedures, departmental supervision and accountability. [21]

Moorfield had become part of the new community-home system, but practice from the system it replaced remained inside it. Its officer in charge had previously worked at an approved school. He told the inquiry that when he was appointed to Moorfield he received no instruction in his new duties and relied entirely on his previous approved-school experience and residential training for his understanding of how an assessment centre should be run. His deputy had also worked in an approved school and similarly received no training or guidance for her new responsibilities.

The connection was recognised at the time. The Director of Social Services identified an approach rooted in the approved-school environment. He acknowledged that methods subsequently regarded as unacceptable had been acquired through years in approved schools and assessment centres, and that predecessor authorities had failed to challenge them. Hytner concluded that old-fashioned institutionalised practices had lingered on at Moorfield.

The consequences were not theoretical.

Hytner found that slapping and slippering boys had been a regular, although not frequent, feature of the regime. Boys had on occasions been punched or kicked. One boy had been picked up by his ears or by his head and ears. The inquiry identified humiliating and harsh treatment, inconsistent approaches to punishment and reward and a breakdown in leadership and communication.

Children could also be kept in their pyjamas as a means of discouraging absconding. That detail matters because it did not disappear with Moorfield. Around a decade later, keeping children in nightclothes during the day reappeared as one of the features of the Pindown regime in Staffordshire.

The similarity does not establish a direct line from Moorfield to Pindown. It does show that a recognisable method of institutional control survived the reforms of the 1970s and could reappear elsewhere years later.

There was also confusion about what constituted corporal punishment. The local authority had prohibited it but had failed to define what the prohibition covered. Hytner attributed that confusion partly to the Social Services Committee and partly to uncertainty in Regulations 10(1) and 10(2) of the Community Homes Regulations 1972.

He recommended that the authority define the conduct covered by the prohibition and press government for clarification of the Regulations. He also recommended that outdated institutional practices and harsh and insensitive treatment end, that training be scrutinised and that children be told about their rights, including their right to complain about ill-treatment.

What makes Moorfield especially important is how the practices were exposed. The challenge came from within the workforce.

Newer and younger staff refused to accept what they found.

They complained about corporal punishment, bullying, humiliation, enforced eating, punitive withdrawal of home leave, labelling and the use of physical force to control children. In their written complaint they made clear that their first responsibility was to the children in their care.

The arrival of new staff challenged what had become normal.

This was not a later generation looking back at the 1970s and applying standards that did not then exist. Staff working inside Moorfield in 1977 were already saying that these practices were unacceptable.

The Director of Social Services recognised the divide himself. He described the approach being challenged as one associated with approved schools and no longer acceptable to a younger generation of staff.

That matters. Harm does not have to be hidden to survive. It can continue openly when it has become the norm. People stop seeing the practice itself as exceptional because it is just how things are done. New people can see what those already inside the culture have learned to accommodate.

Moorfield also prevents this history being reduced to one bad individual.

These practices had been carried out openly. Management had visited. Social workers placed children there and, according to the record from the time, generally regarded the centre favourably. The Director himself acknowledged that previous management should have noticed what was happening and acted.

The officer in charge was suspended while the concerns were investigated. Serious concerns were upheld, and he received a final warning before returning to Moorfield in the same position. Transfer was considered the ideal alternative but was rejected as impractical. Staff who had raised the concerns were commended for doing so, while some were offered transfers because management recognised how difficult it might be for them to continue working there.

The uncomfortable question is therefore not simply why one man behaved as he did. It is how practices could become sufficiently normal that they continued openly until new staff refused to accept them.

Those who were raised in these regimes deserve that explanation.

They deserve more than an acknowledgement that harmful practices occurred. They deserve to know how those practices were allowed to continue, why adults and organisations accommodated them, and what eventually caused them to be challenged.

The approved schools had gone. Their history had not.

Their workforce, training, assumptions and practices travelled into parts of the community-home system that replaced them.

Structural reform changed the legal category and organisation of the institution.

It did not, by itself, change the practice inside it.

That history is also carried by the adults who were children during the transition. David Jackson's *Oi*, and *Snowball*, which brought that story to film, belong within that evidence. They tell us something an administrative record cannot. [144]

Official inquiries tell us what institutions recorded, investigated and concluded.

The adults who were children tell us what those institutions were like to live in.

Neither tells us that every home was the same. Hytner itself prevents that conclusion. It found much at Moorfield that it regarded positively alongside practices it condemned. Children could value adults and places in which harmful things also happened. Committed staff and unacceptable treatment could exist in the same home.

Residential care was not a single story then any more than it is now.

But variation between homes cannot be used to obscure the survival of practices across structural change.

There is another limitation to the history we inherit.

We know as much as we do about Moorfield because staff challenged what they saw and an inquiry was eventually commissioned.

An inquiry creates a documentary record. Allegations are gathered. Witnesses are heard. Decisions and correspondence are preserved. Findings become part of the history available to those who come later.

Where no inquiry follows, much less may survive. What remains may be carried only in the memories of those who were there.

Inquiry reports therefore tell us what was exposed and investigated. Their absence cannot tell us that nothing happened.

That distinction matters when we reconstruct the history of residential child care.

Eventually government itself recognised that the questions of care, control and discipline remained unresolved.

In 1979, it established a working party chaired by William Utting to examine control and discipline in community homes. Its report followed in 1981. [22]

Corporal punishment did not disappear when approved schools were reorganised. Government advice moved against its use during the late 1970s, but it was not formally prohibited in children's homes until 1990. [25]

The history shows that practice was shaped through several routes.

People carried what they had learned.

Managers influenced what was accepted.

Organisations authorised particular practices. That remains relevant today. In the use of physical intervention and restraint, organisational policy and training still shape what staff are taught, permitted and expected to do.

Regulation permitted some things and prohibited others and still does.

And workers challenged what those around them had come to accept.

Pindown later provided clearer evidence of how practice could travel.

During the 1980s, a particular approach to controlling children developed in Staffordshire and spread between establishments through professional relationships, managerial influence and staff movement.

One of its features was already familiar. Children could be kept in nightclothes during the day as part of the regime of control. At Moorfield, children had been kept in pyjamas to discourage absconding a decade earlier. The two inquiries do not establish that one practice was copied directly from the other. They do establish that the same kind of controlling practice could survive, disappear from view and reappear elsewhere.

The Pindown inquiry also recorded something equally important. [26]

When the approach was proposed in another home, staff rejected it.

It was not introduced.

Practice could travel.

So could methods of control.

But practice was also challenged.

Alison Taylor's experience in North Wales shows what challenging harmful practice could cost. She raised concerns about what children were telling her and, when those concerns were not adequately acted upon by the authorities responsible for their care, continued to take them further. [182]

She was suspended and dismissed.

But she did not stop. She continued gathering information from young people and took her concerns to the police and eventually to the press and television. Her persistence helped bring abuse that had not been adequately addressed into public view.

The significance of her experience is not simply that she was eventually vindicated. It is what happened while she was trying to be heard.

The Waterhouse Inquiry itself recognised Taylor's treatment as illustrating what can happen to a whistleblower. Rather than her concerns immediately producing an examination of what might be happening to children, the credibility and conduct of the person raising them became part of the story. [182]

The person exposing the problem can become the problem.

What followed was not a simple story.

There had been serious abuse. Children had not been believed and some abusers had escaped justice. The police response was inconsistent. Investigations widened and prosecutions followed. [182,189]

That led to two inquiries. The first, chaired by John Jillings, a retired director of Derbyshire Social Services, and commissioned by Clwyd County Council, examined the abuse and the failures that had allowed it to continue. Its findings were highly critical, but the report was not published in full at the time. [189]

Concern continued and, in 1996, the much larger Waterhouse Inquiry was established. Its report, *Lost in Care*, was published in 2000. [182,189]

But the response to historic abuse created another danger.

Large retrospective investigations increasingly relied upon police trawling, tracing former residents and asking about events that had sometimes happened decades earlier. Compensation was available and was being paid. Genuine victims could properly receive compensation. But the prospect of compensation, the way some witnesses were approached, and other possible inducements became part of growing concern about the reliability of some allegations. [189,190]

The investigations exposed genuine abuse and brought offenders to justice. But false allegations were also made, prosecutions failed and some convictions were later found to be unsafe. [190]

By 2002 the House of Commons Home Affairs Committee had concluded that the over-enthusiastic pursuit of historic allegations of abuse in children's homes had produced "a new genre of miscarriages of justice". [190]

The earlier failure had been not to listen to children. The answer could not be to stop testing what was alleged.

Children had to be heard.

Too many were not.

Allegations had to be investigated.

Too many were not.

Abusers had to be brought to justice.

Too many were not.

But innocent people had to be protected from wrongful accusation and conviction.

That danger did not disappear with the historic children's-home investigations.

Years later, the case of Carl Beech demonstrated the danger from the opposite direction.

Beech first complained to police in late 2012, in the aftermath of the revelations about Jimmy Savile. He alleged that he had been sexually abused by his stepfather and by a group of men, naming Savile but no other identifiable living suspect. The investigation was passed to Wiltshire Police. No supporting evidence was found and, because no living suspect could be identified, the investigation was closed as undetected in May 2013. [191,195]

Beech did not stop there. In September 2013 he applied to the Criminal Injuries Compensation Authority for compensation. He also wrote extensively online about his claimed experiences and came into contact with journalists. By October 2014 his allegations had expanded dramatically. He now named senior politicians, military figures and former heads of the intelligence services and alleged organised sexual abuse, torture and the murder of children. Those allegations led to the Metropolitan Police investigation Operation Midland. [191,195]

The response was very different from that of the earlier investigation. In December 2014 a senior Metropolitan Police officer publicly described Beech's allegations as "credible and true", although their credibility had not been established and significant inconsistencies had not been resolved. Sir Richard Henriques later concluded that those words should never have been used and that the decision to state publicly that police believed Beech was wrong. He found that the prevailing approach of believing complainants could inhibit the impartial questioning and testing that an investigation required. [195]

There was another extraordinary feature. While Beech's allegations were being made and investigated, he was also a volunteer for the NSPCC. From November 2012 until July 2015, he delivered safeguarding assemblies and workshops to children in primary schools as part of its Speak Out Stay Safe programme. There were no complaints about his work for the charity and there is no evidence that he used those sessions to discuss his own claimed experiences. The significance lies in the overlap. A man whose allegations were acquiring increasing public and institutional authority was at the same time occupying a trusted safeguarding role with children. [191]

In April 2015 Beech received £22,000 from the Criminal Injuries Compensation Authority. Henriques later criticised the fact that an Operation Midland officer had offered to assist progress of the claim while the police were still determining whether Beech was a victim of crime. He concluded that doing so prejudged the outcome and made it more difficult subsequently to discontinue the investigation. [191,195]

Operation Midland eventually closed in March 2016 without anyone being charged. Beech himself was subsequently investigated. He was charged in 2018 and, in July 2019, convicted of twelve counts of perverting the course of justice and one count of fraud. He was sentenced to eighteen years' imprisonment. The sentencing judge concluded that his allegations had been a deliberate and sustained fabrication. [191]

The lesson is not that people who disclose abuse should be approached with suspicion. The failures exposed by earlier inquiries show why children and adults reporting abuse must be listened to and taken seriously. But listening is not the same as believing without inquiry.

Beech's case demonstrates what can happen when claimed personal experience begins to acquire an authority of its own. His allegations attracted media attention, generated a major police investigation and resulted in compensation. More importantly, an institutional commitment to believing the complainant contributed to the normal processes of curiosity, testing and challenge being weakened.

Personal testimony can be powerful evidence.

It cannot become a substitute for evidence.

His case provided another warning. The importance of listening to allegations of abuse does not remove the need to test them.

Failure to listen can protect abusers.

Failure to test can destroy innocent people.

Safeguarding requires both.

Nor did the later Independent Inquiry into Child Sexual Abuse discredit the history of abuse exposed by Jillings and Waterhouse. Later investigations identified further offences and further offenders. IICSA placed that history within something much wider. [71,189]

It found sexual abuse not only in residential care but in foster care, schools, custodial institutions, religious organisations and other settings in which adults and institutions exercised authority over children. [71]

Its investigation in Nottinghamshire is particularly important. It found widespread sexual abuse in both residential and foster care and identified convictions of residential workers and foster carers. [72]

Residential child care cannot deny its history. But neither should that history be used as though abuse belonged uniquely to residential care. IICSA demonstrated that it did not.

The recurring questions are wider ones.

Who had access to children?

Who exercised power over them?

Who noticed what was happening?

Who believed the child?

What information was already known?

And who acted?

The history therefore contains more than one warning. Harm can survive because children are not believed and adults who raise concerns are silenced. But injustice can also follow when the determination to correct that failure overtakes the obligation to test evidence properly.

Both failures belong to this history.

Taylor had lost her career in social work in 1987. By the time the scale of the North Wales failures was publicly acknowledged in February 2000, she had become an established crime writer. Her first novel, *Simeon's Bride*, was published in 1995.

She had lost her career in social work, but what she had encountered there reappeared in her writing. Children, abuse, institutional authority and the failures of adults recur across her fiction. *In Guilty Night*, published in 1996, she returned directly to residential care through the death of a fourteen-year-old boy who had been living in a children's home, while *Child's Play*, first published in 2000, placed the death of a girl within the closed world of a boarding school. A later academic study of Taylor's fiction concluded that most of her work contained some exploration of crimes against children. [197,198]

There is something important in that chronology. The social worker who had been dismissed after refusing to stop asking questions about children did not simply disappear from the story. She continued asking some of those questions through creative writing.

That history matters alongside Moorfield.

At Moorfield, newer staff saw practices that others had learned to accommodate and challenged them.

In North Wales, Alison Taylor continued to raise concerns when the systems around the children did not respond adequately.

In both, what eventually became visible depended upon somebody refusing to accept what they were seeing or hearing.

That is the important distinction.

People move between organisations.

Managers move.

Training moves.

Language moves.

Ideas about children and behaviour move.

Assumptions about authority, control and what constitutes acceptable practice can move too.

That does not mean that one institutional culture is simply transferred intact from one establishment to another.

Culture is made within organisations.

But some of the ingredients from which culture develops can travel.

A practice carried by one worker may be challenged and disappear. The same practice, reinforced by several people, supported by management and accepted by an organisation, can become part of how that organisation understands itself and the children for whom it cares.

Pindown demonstrates both possibilities.

Practice travelled.

It was also challenged.

That distinction matters.

Professional knowledge cannot simply mean learning the approved practice of the present.

It must include the capacity to recognise harmful practice, question what has become accepted and challenge authority when necessary.

None of this alters the harm suffered by the children, or the burden carried by those who tried to expose it.

We cannot deny what history tells us.

Children are harmed by adults and sometimes by each other.

Where children harm other children, the responsibility of adults to recognise, prevent and respond to that harm remains.

They have been harmed in families, foster homes, children's homes, schools, institutions and other places intended to care and protect them. No setting is made safe simply by the language used to describe it.

Family does not guarantee safety. Institution does not guarantee harm. What matters is what adults do, what children experience, how they communicate it, who recognises it, who believes them and whether somebody acts.

The history of foster care raises a different question.

How is harmful care exposed when there is no workforce present to witness the caregiver's practice?

Foster care takes place within a private household. That privacy is part of what enables fostering to become family life. But it also creates a different safeguarding problem. Much of the daily care takes place without another professional there to see it.

The child may be the only person who knows what happens after the social worker leaves.

This is not a theoretical concern.

Dennis O'Neill died in 1945 following cruelty in the foster home in which he and his brother Terence had been placed. His death led to the Monckton Inquiry and became part of the history behind the post-war reform of children's services. [180,181]

Decades later, Terence told what had happened to them in *Someone to Love Us*.

The failure to protect Dennis O'Neill shows that serious harm in foster care was already part of the evidence driving post-war reform.

Roger Roberts tells another story from the same generation in *A Childhood Crushed*. His foster mother abused him and changed his name. [186]

Billy became Roger.

It was only when he accessed his care records at the age of 81 that he discovered professionals had raised concerns and that his treatment had been documented at the time.

He had not known that.

The system knew, and yet he was left unprotected in that placement.

And that changes the question.

The problem was not no information.

The information was there.

By 1997, William Utting's *People Like Us* was again examining abuse and safeguarding in care. It recognised abuse in foster care as well as residential settings and drew attention to the particular vulnerability of children living away from home.

The 2007 Eunice Spry case later exposed another version of the problem. Serious abuse continued for years within a household in which children had been fostered and adopted. [184]

The subsequent Serious Case Review did not reveal an absence of professional involvement.

It revealed repeated involvement.

Concerns had arisen.

Information existed.

Professionals knew the family.

Yet the pattern was not sufficiently recognised or acted upon. Concerns considered separately could fail to reveal what they showed when pieced together. Positive views of a caregiver could influence the interpretation of later information. Children were not always seen independently of the adult caring for them.

Again, parts of the story were already there.

Harm does not always remain hidden because nobody knew. Sometimes what was known failed to ensure protection.

You cannot know what you don't know. But you cannot not know what you do know.

Biehal and colleagues later provided a wider evidence base through their UK study of allegations concerning abuse and neglect in foster and residential care. Their research established that abuse and neglect by caregivers occurred in both settings. [183]

It also drew attention to an important difference.

Residential care takes place in a comparatively public environment.

Foster care takes place within the private domain of the family.

That difference affects how harmful care becomes visible.

Bill Rathbone provides another example, this time from a case that came to court in 2015, of what can happen when the reputation of the caregiver becomes part of the safeguarding problem. [185]

He had fostered many children and had been publicly recognised and praised for his work. He was later convicted of child sexual abuse.

One of the children he abused said she had believed she would not be believed because of the recognition and standing he had acquired.

Sometimes the caregiver's reputation carries more weight than the child's account or is powerful enough to deter the child from telling at all.

Reputation can therefore do more than make harm difficult for adults to recognise.

It can affect whether a child believes there is any point in telling, or the price of telling is too high.

IICSA later provided much wider evidence. Its Nottinghamshire investigation identified sexual abuse in both residential and foster care and serious failures in the response to allegations against foster carers. [71,72]

Children were not always believed.

Professionals sided with the foster carer.

Previous concerns were discounted.

Children remained in placements despite information that should have prompted much greater scrutiny.

Further children were harmed.

So, the question is not simply whether children tell.

It is what happens when they do.

Serious Case Reviews and later Child Safeguarding Practice Reviews matter for precisely this reason.

They allow us to look backwards.

What happened?

What was already known?

Who knew it?

Was the child seen alone?

What did the child say?

How was the caregiver understood by professionals?

Were earlier concerns connected with later ones?

What finally produced action?

And why, sometimes, did action not follow?

Care records tell us something else.

They tell us what was written down at the time.

But Roger Roberts' story demonstrates the limitation of recording.

Something can be known.

Something can be written down.

Professionals can raise concerns.

And a child can still be left there.

A later example illustrates the same problem. Documented evidence of the routine use of dangerous restraint practices was visible within the regulatory history of a service, yet had not prompted effective intervention. Concerns were raised with Ofsted, placing authorities, the Children's Commissioner, the Children's Minister and eventually the Ombudsman, but no independent inquiry followed.

This leaves a question that still matters. If a harmful practice has become normal within the care a child receives, how is that child expected to recognise that what is happening is wrong, know that it can be challenged and find their own way to an external complaints process? And when an adult recognises it and raises concerns through the available routes, where do they go when the system at its highest level does not listen?

That experience does not establish what happened elsewhere.

It establishes something narrower.

Evidence can exist.

It can be recorded.

It can have been visible to those responsible for oversight.

It can subsequently be reported through multiple routes.

And still no independent inquiry may follow.

The absence of an inquiry is therefore not evidence that there was nothing to investigate.

Nor is recording, by itself, protection.

A record is not protection. Inspection is not protection. Reporting is not protection unless somebody recognises what the evidence means and acts on it.

But there is a further difficulty.

Sometimes there is no record.

Sometimes a child does not tell.

Sometimes a child tells and is not believed.

Sometimes what is said never reaches a professional record.

And sometimes the hidden story may never be told.

You cannot know what you don't know.

Where a child never tells, or tells nobody who records it, the caregiver's reputation may be the only version of the relationship that survives.

That does not make the public account reliable.

It means we cannot assume that it is complete.

Safeguarding history is therefore inevitably a history of what became known.

Some harm becomes visible and produces action.

Some is recorded but produces no effective action.

Some is disclosed and not believed.

Some is recognised only when another child speaks.

Some is reconstructed decades later from care records.

Some is told much later by the adults who were children.

Some may never be told at all.

That is why memoir, testimony, art and poetry belong within this history alongside inquiries, Serious Case Reviews and administrative records.

The adults who were those children can tell us what the official record cannot tell us on its own.

Terence O'Neill tells us what it was like to survive a foster placement that became part of national policy history.

Roger Roberts tells us what it means to discover, eight decades later, that adults had recorded concerns about his 'mad' foster mother and left him in her care.

Through *Oi* and *Snowball*, David Jackson shows what institutional care in another period looked and felt like from the child's side of the care journey.

Paul Yusuf McCormack used poetry and art to describe abuse, rejection and the labels imposed upon him by the nuns who ran the home. [187]

His work also draws attention to something more easily overlooked.

Identity could be taken from children as well as relationships, homes and belongings.

McCormack spoke about the importance of a child's name. His own was changed.

Yusuf became Paul.

Roger Roberts tells another version of that history.

Billy became Roger.

These were not simply changes in what a child was called. In their accounts they belong to a wider exercise of adult authority over children's identity.

Adults decided where children would live.

Who would care for them.

Which relationships would continue.

What history would follow them.

And sometimes even what name they would answer to.

None of this means that every foster home was unsafe or every children's home harmful.

It means that neither can claim immunity from history.

Residential care does not have a monopoly on abuse. Fostering does not have a monopoly on love or safety.

The mechanisms through which harmful care is sustained and exposed may differ.

In residential care, other workers may see practice. Harmful methods can become embedded through staff groups, management, training and organisational culture. Other workers can also expose them.

In foster care, much of the daily practice happens within a household. Safeguarding therefore depends heavily on people outside that household seeing the child, seeing them alone, listening to what they say and bringing together what is already known.

So, the questions become unavoidable.

Who sees the child away from the caregiver?

Whether children tell.

Who hears them?

Who believes them?

Who joins together concerns recorded at different times by different professionals?

Who questions the account of an adult who has been assessed, approved and trusted?

Who notices when reputation begins to determine how new evidence is interpreted?

Who listens to the person raising concerns when doing so is uncomfortable for the organisation?

And what finally produces action, or fails to do so?

The history of adoption cannot be placed outside those questions either.

A change in legal status cannot guarantee safety. Nor does becoming part of a legal family remove the possibility of abuse. Where serious harm occurs following adoption, the same questions must be asked about what was known, what was missed and what safeguards failed.

The purpose of examining this history is not to establish which part of the care system has the cleaner record.

There is no helpful league table of harm.

The more important question is whether we are prepared to examine every part of state-arranged care with the same seriousness.

If government intends to expand fostering while using residential care for far fewer children, it cannot examine the regimes, cultures, abuse and failures of residential care while presenting fostering primarily through the language of family, home and normal family life, whatever that may be.

Both histories belong inside the same inquiry.

Residential child care cannot divide its history into good and bad traditions

The history also resists another simple division.

It cannot be divided neatly between controlling institutions on one side and enlightened therapeutic practice on the other.

Therapeutic residential child care has its own long history.

Donald Winnicott and Clare Britton were writing about residential management as treatment in the 1940s.

Barbara Dockar-Drysdale developed another therapeutic tradition at the Mulberry Bush.

Bowlby's work on separation and attachment became another major influence on how children's relationships, loss and placement disruption were understood.

Later approaches included therapeutic communities, attachment-based practice, social pedagogy, developmental approaches, trauma-informed care and other models.

These traditions have contributed important knowledge about relationships, development, behaviour and the therapeutic possibilities of everyday residential life.

But professional and therapeutic language does not place practice outside scrutiny.

The Kirkwood inquiry into abuse in Leicestershire examined Frank Beck's claimed therapeutic influences. Wendy Rowell had previously worked at the Mulberry Bush and later managed the unit in which Beck worked. Her evidence distinguished the therapeutic practice she knew from the methods Beck later developed.

That distinction matters.

Encountering therapeutic ideas is not the same as having the knowledge, training and supervision required to practise them.

Ideas travel through people.

They can be understood.

Adapted.

Partially understood.

Misunderstood.

Distorted.

And professional language can give them an authority they have not earned.

A therapeutic label or professional affiliation does not, by itself, demonstrate therapeutic practice.

The test is what children experience.

Some practices were accepted.

Some were overlooked.

Some were formally authorised.

Some travelled through people.

Some acquired professional or therapeutic justification.

Some were challenged and stopped.

Others continued until inquiries, scandals or prosecutions exposed them.

But the history of failure is not the whole history either.

The history of failure is not the whole story

The literature about residential child care is often weighted towards failure because inquiries, investigations and published reports are usually produced when something has gone wrong.

Moorfield, Pindown, Leicestershire, North Wales and the later IICSA investigations exist because children were harmed.

They tell us about abuse, poor practice, failures of management, weak supervision, inadequate scrutiny and children who were not listened to.

That evidence has to remain part of the history.

But inquiry literature cannot provide a complete history of residential child care.

It tells us most about the places and people where something went seriously wrong.

It tells us much less about the relationships in which residential workers cared for children, knew them well, advocated for them and exercised judgement on their behalf.

The people who abused children or misused their authority cannot be allowed to describe an entire workforce.

Abuse occurred in foster care too. Social workers have also been convicted of abusing children.

That does not make fostering or social work inherently unsafe.

The same standard should apply to residential child care.

Its failures should be identified precisely.

So should its strengths.

Sir Martin Narey's 2016 review described a sector in which the overwhelming majority of children's homes were judged good or outstanding and argued that residential workers deserved greater recognition.

There is an older history of good practice too.

Andrew Adonis, now Lord Adonis, provides one example.

What the care experience of Andrew Adonis tells us

Andrew Adonis occupies an unusual and important place in this history.

As a child he spent time in care. He later became one of the most influential figures in New Labour's public-service reform programme, particularly in education, where he was closely associated with academies and with the development of new professional and leadership routes outside established structures.

His later influence matters to this review because that approach to reform would travel beyond education, through Teach First and Frontline and into contemporary children's social-care reform.

But before considering Adonis as a reformer, there is something important in his own experience as a child in care.

In evidence to the House of Commons Education Committee, Adonis described being eleven years old and living in a children's home when his social worker and the woman managing the home concluded that boarding school was right for him.

Camden did not normally have boarding-school placements among the options available to children in care.

They continued to press the case.

The decision eventually reached the leader of the council.

Adonis later described those practitioners as having made it their business to secure the placement because, in his circumstances, they believed it was the right thing to do.

The significance is not boarding school.

It is what those practitioners knew and what they did with that knowledge.

More than fifty years ago, practitioners could understand an individual child's circumstances well enough to recognise that established policy did not fit him, exercise professional judgement and continue making the case until the system changed its mind.

That knowledge belongs to the history of residential child care just as much as Moorfield and Pindown do.

It is less visible because good care does not generate public inquiries.

The history of residential child care is not only the history of what practitioners did wrong. It is also the history of what many knew, understood and did on behalf of children.

Residential workers see children at times when few other professionals do.

At breakfast, after school, when plans have gone wrong, when somebody has disappointed them, when they are angry, when they are frightened, when they return after going missing, when they succeed, when they fail and when they try again.

That proximity can produce knowledge that is different from an assessment conducted at intervals.

It does not make residential practitioners infallible.

The history shows very clearly that they are not.

But professionalisation should build on that knowledge rather than assume that the workforce is waiting for somebody outside it to supply an answer.

Start with the child, not the preferred placement

Adonis's history matters for another reason.

The accepted policy response did not fit him.

The practitioners closest to him recognised that.

They challenged it.

His story cannot tell us what is right for another child.

That is precisely the point.

A system that decides in advance which type of placement it prefers risks overlooking what an individual child needs.

Government has already said residential care should be used for far fewer children.

Fostering is being expanded.

Residential care is to become smaller and more specialised.

But Adonis's own experience points to a different starting point.

What does this child need?

Not which placement type government prefers.

Not which service is cheaper.

Not which category government wants to expand.

Youth justice separated again

The framework created in 1969 did not remain intact.

During the 1980s and 1990s youth justice progressively moved away from the welfare framework in which offending and child welfare had been deliberately brought closer together.

Diversion, cautioning and intermediate treatment reduced the number of young people drawn into residential provision through offending, while responsibility for more serious offending increasingly developed along a distinct youth-justice track.

The Children Act 1989 drew the boundary more clearly between care proceedings and criminal proceedings. Offending itself was no longer a route by which a child should be placed in care.

That was an important distinction.

It also changed the residential population again.

Young people who might once have entered a community home through the youth-justice system increasingly entered different forms of youth custody or community supervision.

The Criminal Justice and Public Order Act 1994 then created Secure Training Centres as another distinct custodial structure.

The Crime and Disorder Act 1998 created a new national youth-justice architecture, including the Youth Justice Board and local multi-agency Youth Offending Teams.

The historical movement is striking.

In 1969 government had deliberately sought to weaken some of the institutional distinction between the deprived child and the delinquent child.

Three decades later a distinct youth-justice system had been rebuilt.

Care and control had not been reconciled. They had been reorganised.

Residential child care became smaller partly because routes into it had been redirected elsewhere.

But care and control have never been completely separated.

Secure children's homes remained positioned across welfare and youth justice.

They could care for children whose liberty was restricted for welfare reasons and children placed through the youth-justice system.

They sit precisely where the administrative distinction between care and control is hardest to sustain.

That matters to the current review because secure care is part of the history of residential child care, not something separate from it.

It exposes one of residential child care's oldest unresolved questions: how children can be cared for when adults are also required to exercise control over them.

Leaving care became another separate system

The history of leaving care reveals the same pattern.

The Children Act 1948 already recognised that responsibility did not necessarily end when a young person left care. Aftercare was part of the statutory framework.

But leaving care gradually developed into a separate field of policy and practice.

Specialist leaving-care schemes expanded significantly during the 1980s. They included 16-plus units, hostels, supported lodgings, training flats and other arrangements intended to help young people make the transition towards independence.

Later came foyers and other accommodation linked to education, employment and training.

The Children Act 1989 and, later, the Children (Leaving Care) Act 2000 strengthened local-authority responsibilities towards young people leaving care.

But they also sat alongside a developing distinction between care and support.

Some accommodation for 16- and 17-year-olds increasingly came to be described not as care but as preparation for independence, semi-independent or supported accommodation.

That distinction did not develop in a legal or regulatory vacuum.

The Children Act allowed local authorities to place some older children in accommodation that was not a children's home. Education and training law also allowed some residential settings for older adolescents to sit outside children's-home registration.

Nor was accommodation outside children's-home registration necessarily beyond legal or administrative oversight.

Different responsibilities sat in different parts of the system.

Accommodation could fall outside children's-home registration while remaining subject to housing requirements and standards. Local authorities commissioned placements and remained responsible for the children and young people they placed there.

But that did not necessarily mean the service itself was routinely inspected.

The regulatory position was not theoretical. Services of this kind could operate with the knowledge of placing authorities and housing departments without being registered as children's homes.

In one case, a complaint that a service was operating as an unregistered children's home led CSCI to examine it and conclude that children's-home registration was not required.

The absence of children's-home registration was therefore not evidence, in that case, that the provider was operating illegally. It was the regulator's conclusion.

That matters because the distinction was not simply between regulated and unregulated provision.

Responsibility could be distributed across housing, social services, commissioning and the regulatory boundary around children's homes.

A service could be known to the state, commissioned by the state and subject to standards while lawfully operating outside children's-home registration.

The question was therefore not simply whether somebody inspected the provider.

The question was also who assessed the placement, who commissioned it, who monitored the young person and who took action if the arrangement became unsuitable.

Alongside these arrangements, an increasingly important distinction developed between accommodation providing care and accommodation providing support.

By 2014, the House of Commons Education Committee was examining the consequences under a title that captured the problem precisely:

Into Independence, Not Out of Care.

The Committee was concerned about variable quality and the absence of individual regulatory oversight of what were then described as other arrangements.

But government did not then accept that creating another regulated sector was necessarily the answer.

It questioned whether additional regulation would automatically produce better accommodation or support. It stressed the importance of flexibility and argued that local authorities should be held to account for the quality of the placements they commissioned.

Ofsted inspection of local authority children's services was part of that accountability.

That decision matters to what happened next.

Provider regulation was not the only means available to protect young people.

Government had chosen to rely upon local-authority responsibility, commissioning, safeguarding and inspection as important parts of that protection.

By 2015, statutory guidance recognised a range of arrangements including supported lodgings, foyers, semi-independent accommodation and floating support.

In 2016, Ofsted made the distinction between care and support explicit.

Accommodation providing care required registration as a children's home.

Accommodation providing support could lawfully operate outside that registration system.

Supported and semi-independent accommodation therefore did not somehow appear outside the law.

Law, policy and guidance had created legitimate routes for older young people to live outside children's homes.

The problem was what happened to those legitimate routes.

As foster placements and children's-home placements became increasingly difficult to find and increasingly expensive, supported accommodation offered another option.

Provision intended to support education, training or increasing independence also offered a low cost alternative to care in a regulated placement.

For some young people that was entirely appropriate.

They did not need another children's home.

They needed somewhere to live, adults to turn to and increasing independence without recreating a children's home environment around them.

But the boundary between support and care was also pushed.

Children whose needs required care were placed in accommodation designed to provide support.

Some children under sixteen were placed in it.

Some provision was poor or unsafe.

Some providers crossed the boundary from support into care and should have been registered as children's homes.

Those were different problems.

Unregulated did not mean unlawful. Unregistered could.

Where care and accommodation were being provided without the registration required by law, the provider was operating unlawfully.

But providers did not place looked-after children in those services.

Local authorities did.

Providers could accept or refuse a placement and carried responsibility for what they provided.

But local authorities assessed the child, decided where the child should live, purchased the placement and remained responsible for the child.

If a provider accepted a child who needed care rather than support, both the provider and the placing authority shared responsibility for that decision.

Provider responsibility does not eliminate commissioner responsibility.

A market does not create its own demand. These placements were being purchased by the state.

Unregistered children's homes make that reality difficult to avoid.

Operating a children's home without registration was already a criminal offence.

An unlawful placement market could not have become established without local authorities placing children there and paying for those placements with public money.

Ofsted was also inspecting local-authority children's services.

That raises another question.

If children whose needs required care were repeatedly being placed in accommodation designed only to provide support, why was that not identified sooner as a placement, commissioning and safeguarding failure?

The provider was easier to see. The local authority that placed the child there and continued to pay for the placement was less so.

By 2019, investigative journalism was bringing serious examples of poor and unsafe accommodation into public view.

Newsnight used the language of Britain's hidden children's homes and focused attention on children living in unregulated accommodation.

The investigation raised legitimate concerns.

But the language mattered.

Ofsted itself distinguished between unregulated and unregistered provision.

Unregulated supported accommodation could be lawful where support rather than care was being provided.

An unregistered children's home was different. If a service was providing care and accommodation and met the legal definition of a children's home, registration was required.

Ofsted also recognised that supported provision was the right option for some young people.

But the media-led campaign was less precise.

A lawful supported-accommodation provider was not the same thing as an unregistered children's home.

A service could be operating lawfully and still be the wrong placement for a particular child.

That distinction mattered because once the problem was framed principally as one of unregulated providers, provider regulation became the go-to solution.

There is little evidence that the decisions behind those placements were examined with the same urgency.

Why were local authorities making these placements?

Who decided that support rather than care was sufficient?

What alternatives had been sought?

Who authorised the placement?

Who paid for it?

What had local-authority inspection said about the use of these arrangements?

Government was responding to intense media and political pressure for action.

Government and the media have an uneasy relationship in children's social care.

The media can expose failures that government, regulators and public bodies have failed to identify or address.

That scrutiny matters.

But intense media attention also creates political pressure to be seen to act.

A complex problem can become a simple headline. The demand for action can then become a demand for an answer that is visible, immediate and easily explained.

Regulation provided that answer.

It demonstrated action.

It did not necessarily establish that lack of provider regulation was the principal cause of the problem.

When government responds to the pressure created by a media campaign, there is a danger that policy begins to answer the way the problem has been presented rather than the problem itself.

The public purse can be left carrying the cost of a response that protects government by demonstrating action rather than solving the underlying problem.

I was in direct contact with *Newsnight* while its investigation was being developed. I explained the distinction between regulated, unregulated, registered and unregistered provision.

Later I sent *Newsnight* Ofsted guidance explaining the difference between care and support and warned them about the potential consequences of introducing Ofsted regulation.

My concern was never that poor provision should be protected from scrutiny.

It should not.

My concern was that different problems were being collapsed into one.

If a provider was operating a children's home without registration, that was an enforcement issue.

If accommodation was unsafe, that was a safeguarding and quality issue.

If a child who needed care was placed in accommodation providing only support, that was a placement and commissioning issue.

If local authorities were repeatedly purchasing such placements because suitable alternatives were unavailable or more expensive, that raised a wider question about capacity, commissioning and local-authority budgets.

Those are connected failures. They are not the same failure.

Government subsequently prohibited the use of independent and semi-independent accommodation for looked-after children under sixteen.

But it did not abolish the model for 16- and 17-year-olds.

Instead it created a new regulatory system.

The Supported Accommodation (England) Regulations 2023 that followed pulled this longstanding type of accommodation within a separate national registration and standards regime.

Providers now had to register with Ofsted.

Services required registered service managers and nominated individuals.

They became subject to national standards, inspection and enforcement.

The legal framework had changed.

The creation of a new regulatory regime did not retrospectively make the previous lawful framework unlawful. It changed the framework.

And it changed something else.

The provider was now regulated.

The provider was regulated. The commissioning problem remained.

Registration did not create more foster placements.

It did not create more beds in children's homes.

It did not remove local-authority budget pressures.

It did not determine whether a child required care or support.

It did not make a placement suitable merely because the provider was registered.

A regulated placement can still be the wrong placement.

The new regulatory regime also had financial consequences.

The registration fee was not the real cost.

Providers now had to meet the costs of registered management, additional policies and recording, supervision and training, quality assurance, regulatory administration and ongoing compliance.

Regulation changed the cost base of the service.

Supported accommodation is not a single model. It ranges from accommodation with limited floating support to accommodation with staff on site twenty-four hours a day.

Weekly fees cannot therefore be compared without knowing what level of accommodation and support is included.

Before implementation, some local authorities anticipated that the new regulatory regime would increase costs.

That was a forecast, not evidence of what every placement actually cost.

What happened afterwards is more important.

Hertfordshire reported that the average cost of an independent semi-independent placement increased from £1,631 a week in March 2022 to £2,263 in March 2023 and £3,395 in March 2024. [205]

The council itself attributed the increase in 2024 to the introduction of regulation for supported accommodation and registration with Ofsted. [205]

Lincolnshire reported an increase in the average weekly cost of supported accommodation from £906.33 in 2023/24 to £1,444.03 in 2024/25. [206]

The increases were not identical and regulation cannot explain every pound.

But there is evidence that regulation added costs, and some local authorities explicitly linked increases in what they were paying to the new regulatory regime.

Government knew the reforms would cost more.

It allocated £123 million to local authorities towards the additional costs of implementation. [207]

But that funding was time limited.

The additional costs of running regulated provision are not.

A fixed pot of implementation funding can quickly be overtaken by recurring increases in placement costs.

Regulation therefore had a price, and ultimately somebody had to pay it.

In a publicly commissioned market, those costs return to the public purse through placement fees.

The cost of the regulatory response was added to the system, while the capacity and commissioning pressures that had helped create the problem remained.

And there is another risk here.

Regulatory creep.

Supported accommodation was deliberately created as something different from a children's home.

The distinction matters.

Young people preparing for independence need opportunities to make decisions, travel independently, cook, manage money, form relationships, make mistakes, experience difficulty and take appropriate risks.

Independence cannot be created by removing every risk from a young person's life.

But regulation does not simply measure a service.

Over time, it can shape it.

The Supported Accommodation Regulations contain four standards rather than the nine Quality Standards applying to children's homes.

The language is different.

The purpose is different.

But much of the regulatory architecture is familiar.

Registered providers.

Registered managers.

Nominated individuals.

Statements of purpose.

Workforce requirements.

Safeguarding arrangements.

Behaviour management.

Records.

Complaints.

Notifications.

Quality reviews.

Inspection.

Enforcement.

The language is different, but much of the regulatory architecture is familiar.

That raises another question.

At what point does applying familiar structures from children's homes begin to change a model whose purpose depends upon remaining different from a children's home?

The distinction cannot be protected simply by calling one model care and the other support.

It has to remain visible in practice.

That also makes the experience of inspectors relevant.

Training in a regulatory framework is not the same thing as experience of the service being regulated.

Cognitive bias is real.

Previous experience can shape what people notice, how they interpret risk and what they expect good practice to look like.

Inspectors are no more immune from that than any other professional.

If an inspector's experience has principally been gained in children's homes, there is a risk that supported accommodation is consciously or unconsciously judged against a different model.

That matters because the inspector holds the power. They do not necessarily hold the knowledge.

The same question applies to Ofsted's leadership. Since Ofsted assumed responsibility for children's social care in 2007, no HM Chief Inspector has been a qualified social worker. Every HM Chief Inspector who has led Ofsted during that period has come to the role through education, education leadership, education regulation or education policy.

Amanda Spielman illustrates the point. A chartered accountant by profession, she had worked in finance and strategy in the UK and the US before moving into education as a founding member of the leadership team at Ark Schools. She later chaired Ofqual. When she was nominated as Chief Inspector, the House of Commons Education Committee noted that she had no direct experience of teaching or children's social care and declined to support her appointment. The government went ahead with the appointment despite the Committee's decision. [65]

The Ark connection did not begin with Spielman. Her predecessor, Sir Michael Wilshaw, had been Director of Education at ARK before becoming Chief Inspector in 2012. Nor did the connection stop at the regulator. Sir Paul Marshall, a founding trustee and chairman of Ark Schools, served as the Department for Education's lead non-executive board member from 2013 to 2016. During part of that same period, Wilshaw was leading Ofsted and Spielman was chairing Ofqual before succeeding him as Chief Inspector. [65]

This brings us back to the question already running through this review: who is given regulatory authority, what knowledge and networks they bring with them, and what knowledge is absent.

Ofsted's leadership matters because it helps determine the framework, priorities and expectations within which inspection operates. Inspectors do not make judgements in a vacuum. They work within Ofsted's inspection framework, guidance, methodology and organisational expectations.

The provider has to respond to the judgement produced through that system. That judgement affects the home's rating, the provider's reputation, registration and its ability to continue operating.

If supported accommodation is intended to remain different from a children's home, it matters whether those regulating it understand that difference in practice as well as in guidance.

Ofsted itself recognises that the boundary between care and support is not always neat.

Young people preparing for independence may need considerable help. Sometimes that help may look very close to care.

The answer cannot be to withdraw appropriate help simply to preserve a regulatory distinction. But neither should the flexibility of supported accommodation become another route through which children who actually require care are placed somewhere cheaper.

That is not simply a question for providers. Local authorities decide where children are placed and remain responsible for ensuring that the placement is capable of meeting their needs. Regulation of supported accommodation cannot compensate for poor assessment, inappropriate commissioning or a shortage of the care a child actually requires.

The model should remain capable of doing what it was created to do.

The danger is not simply that supported accommodation begins to resemble a children's home in its regulatory architecture. The greater danger is that regulation changes practice.

A service intended to prepare young people for adulthood can become increasingly risk averse, prescribed and controlling.

There is growing evidence that state care can impose burdens of its own. Children and young people can experience loss of control, uncertainty, instability and institutionalisation alongside whatever adversity brought them into care in the first place. [203]

That matters here because preparing for adulthood requires increasing autonomy.

Young people need opportunities to exercise judgement, make decisions, take appropriate risks, get things wrong, experience consequences and learn from them.

Independence cannot be learned if the opportunity to exercise it is progressively removed.

There is also a danger of creating a cycle. The more controlling a service becomes, the more likely some young people are to resist it. That resistance can then be interpreted as further evidence of risk, producing still more control.

A service created to support increasing independence can therefore begin to work against its own purpose.

Care can protect children from harm. It can also add burdens of its own. Regulation intended to make supported accommodation safer should not inadvertently add to them.

Regulation can also change who is able to provide the service.

Compliance creates fixed costs. Larger organisations can spread those costs across more placements and services. Smaller organisations cannot do so as easily.

Ofsted registration may also give commissioners greater confidence in purchasing from organisations able to demonstrate established regulatory systems, infrastructure and compliance capacity.

That does not mean regulation necessarily reduces the overall number of placements. The supported-accommodation market has continued to grow.

But growth alone tells us very little about what is happening to the composition of that market.

A growing market can still become more concentrated. Smaller providers can leave, sell or decide that the regulatory and financial burden is no longer worth carrying while larger organisations continue to expand.

That distinction matters.

The question is not simply whether regulation has increased the amount of supported accommodation available. It is whether it is changing the kind of supported-accommodation market we have.

A market can expand while becoming more difficult for smaller providers to operate within. It can gain capacity while losing diversity.

That matters because smaller local providers may bring something that cannot easily be reproduced through scale.

Local knowledge.

Relationships.

Flexibility.

Continuity.

Different models of support.

Regulation can therefore change not only what a service costs, but the shape of the market itself.

Commissioning can do the same.

If commissioning becomes increasingly regional, standardised and dependent upon providers able to operate at scale, the combined effect of regulation and commissioning may reshape supported accommodation far beyond the original intention of improving safeguards.

The history of leaving care therefore brings us back to the same question that runs through the history of residential child care.

What problem were we trying to solve?

Aftercare existed in legislation in 1948.

Specialist leaving-care services developed.

Supported accommodation emerged as part of an attempt to help older adolescents move towards independence.

A distinction was then drawn between care and support.

That distinction was administratively useful.

Children’s needs were never so easily divided.

The problem was not the existence of supported accommodation.

For some young people it was, and remains, exactly what they need.

However long the state is prepared to buffer the transition, responsibility for self ultimately passes to the adult the child becomes, except where capacity means that responsibility must remain shared.

There is an uncomfortable contradiction here.

The law is prepared to hold a child criminally responsible from the age of ten, while eighteen remains the age of majority.

Preparing young people for that responsibility matters.

The problem was whether a legitimate route towards independence had also become a cheaper substitute for care for children whose needs required something more.

Regulating the provider does not answer that question.

The test is what has changed for children.

Are young people safer?

Are children who need care now more likely to receive it?

Has appropriate independence been preserved?

Have good lawful providers remained available?

Has genuine placement choice increased or narrowed?

Are local authorities making better placement decisions?

Or has Ofsted registration simply created greater confidence in purchasing a placement that may still be wrong for the child?

Compliance is not the same as suitability.

Regulation should protect young people from poor provision.

It should not gradually transform good provision into something it was never intended to be.

And if regulation changes the provider without addressing the commissioning, sufficiency and financial pressures that caused children needing care to be placed there in the first place, a reform introduced to protect young people may fail them again.

Contradictions and casualties

Throughout this history there are contradictions.

There are also casualties.

The casualties are not always the consequence of malicious policy.

They are often children and young people who fall between categories shaped by administration, policy and cost.

The adolescent whose foster placements repeatedly break down before residential care is considered.

The young person whose eighteenth birthday changes their legal status without changing their needs.

The 16-year-old considered ready for independence because the provision available is a lower cost 16-plus service.

The young person placed in accommodation defined as support rather than care because policy has created that boundary.

The adult who still needs statutory care-leaver support years after the formal care relationship has ended.

Age thresholds expose the contradiction particularly clearly.

In England and Wales, the age of criminal responsibility is ten. From that age a child can be arrested, prosecuted and convicted of a criminal offence.

That was also the age of criminal responsibility at the time of the Bulger case. But children aged ten to thirteen then had an additional protection. The presumption of *doli incapax* required the prosecution to establish that a child understood that what they had done was seriously wrong, rather than merely mischievous. The Blair government abolished that presumption in 1998. [32]

The contrast is striking. The law removed an additional protection from children aged ten to thirteen. In the years since, developmental science has strengthened the evidence that judgement, impulse control and decision-making continue to develop through adolescence. [136]

Yet elsewhere the same state recognises that responsibility develops gradually.

At 16 and 17, some looked-after children can live in supported accommodation designed around increasing independence.

At 18, childhood ends in law.

Care-leaver support can continue beyond it.

Government is now proposing to give 16- and 17-year-olds the vote.

These are different decisions.

But together they expose how differently the state understands childhood, maturity and responsibility.

Children do not develop according to administrative thresholds.

Scandals produced evidence of whole-system failure

By the late 1980s and 1990s, successive inquiries and prosecutions had created a profound crisis of confidence in residential child care.

Pindown, Frank Beck, North Wales and other investigations exposed serious abuse and failures to listen to children.

But the literature that followed did not identify residential workers alone as the problem.

Utting's *People Like Us* identified failures in recruitment, management, supervision, inspection and safeguarding.

Responsibility extended across local authorities, police, inspectorates, government and other organisations responsible for protecting children.

When government responded to Utting, the then Secretary of State for Health, Frank Dobson, described failure across social-services management, councils, police, schools, voluntary organisations, inspectorates, government departments, ministers and Parliament.

The whole system had failed.

That finding matters.

Residential abuse was real.

But the inquiries were also describing failures of governance, management, workforce development, oversight and placement planning.

Utting also identified insufficient placement choice, damaging sequences of moves, chronic staffing difficulties, poor workforce status and the continuing need for residential care.

The 1998 Health Committee did the same.

Its concern about safeguarding sat alongside its conclusion that residential capacity had already been reduced too far.

The literature therefore contained several findings at once.

Children needed stronger protection.

Management and accountability needed improvement.

The residential workforce needed better training and status.

Placement choice needed protecting.

Residential capacity remained necessary.

Fostering could not meet every need.

The important question is which of those findings travelled into policy.

The scandals also created political opportunity

The scandals did more than produce evidence.

They changed the politics of care.

Tony Blair had already shown how a shocking event involving children could change a wider political argument.

The killing of James Bulger in 1993 became part of a wider political debate about youth crime in which Blair, then Shadow Home Secretary, was already repositioning Labour on an issue traditionally regarded as Conservative territory.

His argument that Labour should be “tough on crime, tough on the causes of crime” became an important part of that repositioning.

The killing of one child could not tell us why children offend.

But it became part of a much larger political story about crime, responsibility and society.

As did the residential care scandals.

Utting and later Waterhouse exposed appalling abuse and failures across the system.

But one political response was a renewed drive towards adoption.

Following Waterhouse, Blair commissioned a review of adoption. Parliament later recorded that concerns arising from residential care contributed to a renewed emphasis on adoption as a route out of care. [192]

That review became part of the policy journey that led to the Adoption and Children Act 2002 and a drive to increase the number of children adopted from care. [35,192]

That is significant.

Evidence of failure within the care system helped strengthen the case for moving more children out of it.

What happened to children after adoption is examined later in this review. What matters here is that Waterhouse had investigated abuse in care. It had not established adoption as the answer to what it found. That was a political conclusion drawn from the evidence. [182,192]

Yet that was not the only conclusion available from the evidence.

Utting had also warned about too little placement choice.

About damaging sequences of placements.

About staffing.

About children being placed in homes unable to meet their needs.

About risks beyond residential care.

And about the continuing importance of residential provision.

The evidence contained more than one story.

Policy did not give each story equal weight.

That matters because it reveals something that runs through the history of children's social care.

A scandal does not determine the reform that follows it.

Someone decides what the scandal means.

A new method of reform

Prime ministers matter in this history.

They do not write every policy, design every service or determine every professional decision. But they help define the problem government believes it is trying to solve.

That matters because the diagnosis shapes the remedy.

Blair came to power in 1997 promising national renewal after eighteen years of Conservative government.

Education was his first priority. Schools, the NHS, crime, welfare and public services were all presented as requiring improvement and modernisation. His argument was that Britain could do better and that existing public services and institutions had to change if they were to deliver better outcomes.

New Labour also came to power at a time when public confidence in important parts of children's social care had been badly damaged.

Quality Protects followed in 1998, introducing national objectives, targets, performance measures and stronger central oversight.

But the Blair years did more than respond to individual failures.

Blair's approach to public services reflected a particular view of established institutions and professional authority. He praised public servants but argued that the post-war welfare model had allowed professionals and managers too much power to define how services were delivered and to what standard.

His answer combined stronger national standards and accountability with greater user choice, contestability, alternative providers and new routes through which change could enter public services.

This was not only distrust of individual professionals.

It was a lack of trust in established public-service structures and professional monopolies to reform themselves.

Once existing institutions are treated as part of the problem, political authority acquires a larger role in deciding who should provide services, who should enter professions, who should lead them and how success should be measured.

That is why the Blair history cannot be separated from the later questions about markets, new providers, regulation, professional routes and where authority sits.

These questions were being raised at the time. Writing in 2002, social-work academic Stan Houston examined the new Framework for the Assessment of Children in Need and their Families. He welcomed its wider attention to poverty, social exclusion and the environment around the child, but criticised its failure

to examine adequately how structural and institutional power operated. He located the framework within New Labour's wider Third Way politics and argued that apparently professional approaches to understanding need could not be separated from political assumptions about the welfare state, inequality and intervention. [194]

The significance is not that Houston's analysis must be accepted. It is that the relationship between professional knowledge, political ideology and the definition of need was already being contested while these reforms were being introduced.

Reform power creates responsibility.

Government cannot claim authorship of transformation when it is announced and later stand at a distance from the consequences of the structures and markets it helped create.

And the significance of Andrew Adonis now changes.

Earlier in this review, his childhood experience showed that, more than fifty years ago, practitioners had enough knowledge of an individual child, and enough authority, to challenge policy when it did not fit that child.

As a policymaker, Adonis would become one of the most influential architects of New Labour's education reforms, which reflected a wider approach to public-service reform based increasingly on changing structures, providers, professional routes, leadership and where authority sits.

During the Blair years, that wider approach became embedded across public services as a way of pursuing improvement through centrally defined priorities, measurable targets, structural reform and greater use of competition and external providers.

Andrew Adonis became central to that approach in education.

Academies were one expression of it.

Teach First was another.

The significance was not simply the programmes themselves.

It was the thinking beneath them.

If established structures were judged unable to improve quickly enough, reform could mean creating new organisations alongside or outside them.

Alternative professional routes could challenge established routes.

New entrants could change professions.

New leadership pipelines could shape who would later influence policy and design future reform.

Changing who entered a profession could become part of changing the profession itself.

Changing who led services could become part of changing what those services delivered.

Moving authority away from existing institutions became part of reform.

Reform was no longer simply something done to structures.

New organisations, new professional routes and new leadership networks became mechanisms through which reform could reproduce itself.

That approach did not remain within education.

It travelled.

Every Child Matters and the reorganisation of children's services

The 2003 *Every Child Matters* Green Paper followed the death of Victoria Climbié and Lord Laming's inquiry. [36,37]

Its ambitions were substantial.

Children should not fall between services.

Agencies should work together.

Problems should be recognised earlier.

Accountability should be clearer.

Children should receive help before difficulties became crises.

But *Every Child Matters* was also a workforce reform programme.

It considered common knowledge and skills, occupational standards, professional routes, leadership, continuing professional development and the organisation of the children's workforce.

There is a historical irony.

Seebohm had moved specialist Children's Departments into generic social services in the name of integration.

Three decades later, *Every Child Matters* moved children's social care away from adult social services and closer to education in another attempt at integration.

The boundary moved again.

And the change did not stop with organisational boundaries.

It affected where authority sat, how accountability worked, whose knowledge carried weight and how the children's workforce was understood.

The shift was happening nationally as well as locally.

In 2003, responsibility for children's social care policy moved from the Department of Health into the Department for Education and Skills. Children's social care was no longer being led nationally alongside adult social care. It had moved into the government department responsible for education.

The Children Act 2004 then placed responsibility for education and children's social services locally under a single Director of Children's Services.

Every Child Matters sought to create a more joined-up children's workforce, with shared knowledge and skills across different professions. Children's social care was therefore moving away from adult social care both nationally and locally, and into structures in which education had a much stronger place.

The change went further. In 2007, responsibility for inspecting and regulating children's social care moved from the specialist Commission for Social Care Inspection into the enlarged Ofsted.

Authority and accountability moved with the structure. So did professional influence.

Many of the same workforce questions are now being asked again.

Knowledge.

Skills.

Qualifications.

Leadership.

Recruitment.

Retention.

Career pathways.

Professional development.

That does not mean another review cannot add anything.

It means these questions have a history.

The present review is not entering unexplored territory.

It is entering territory already shaped by previous attempts to answer many of the same questions.

There is a wider historical parallel here.

In the 1970s, children's social care was also being reorganised while the organisations responsible for delivering it were changing around it. Specialist Children's Departments disappeared into new Social Services Departments. The community-home system reorganised residential provision. Then, from 1974, local government itself was reorganised, with authorities abolished, merged and given new geographical boundaries.

Several parts of the system were changing at the same time.

And that is happening again.

The current programme of local government reorganisation is changing some of the authorities responsible for children's social care at the same time as government is changing commissioning, fostering, residential care and the workforce.

The two periods are not the same. But the historical question is the same.

What happens to knowledge, experience and accountability when several parts of the system are reorganised at the same time?

Statutory responsibility may continue, but organisations change. Leadership changes. Teams move. Relationships can be disrupted. Operational knowledge has to be transferred and institutional memory has to survive the transition.

There is an evaluation problem too. When several reforms are implemented at the same time, it becomes harder to establish which change produced which consequence.

Structural reform does not happen around children's social care. It becomes part of children's social care.

Accountability became concentrated too

Every Child Matters did not simply integrate services. The Children Act 2004 created the Director of Children's Services as a single point of responsibility for education and children's social services within each local authority.

That was intended to make accountability clearer.

Moorfield provides an earlier comparison. Serious failures had been exposed within a service for which the Director of Social Services held senior responsibility. The Director accepted that previous management should have recognised what was happening and acted, but the inquiry did not result in his removal.

By the time of Peter Connelly's death, the structure of accountability had changed. Responsibility for education and children's social services had been located in the role of the Director of Children's Services.

The death of Peter Connelly and the subsequent treatment of Sharon Shoesmith exposed what that could mean. As Director of Children's Services, she was the senior officer responsible for the service. Following the Ofsted inspection, the Secretary of State directed her removal before she had been given an opportunity to respond to the findings. The Court of Appeal later held that the process was unlawful.

The contrast matters. Moorfield had exposed serious failure without the removal of the Director of Social Services. Three decades later, accountability for a much wider system had been concentrated in one senior post.

The point is not to revisit responsibility for Peter's death. Accountability for a service is not the same as causing everything that went wrong.

A structure can concentrate responsibility in one office without making one individual the sole cause of a whole-system failure. Concentrated accountability can make responsibility clearer. It can also make it politically easier to locate system failure in an individual rather than the system.

But accountability cannot stop with the service being inspected. If the task of inspection is to provide public assurance about the quality and safety of services, the regulator's own judgements must also be open to examination when they fail to reveal what is happening.

This case raises a question that goes well beyond Sharon Shoesmith.

Who is accountable when the system designed to judge whether services are safe says they are good and subsequently finds that they are not?

Power and accountability should travel together. But accountability must remain proportionate to actual authority and to the evidence.

Ofsted cannot escape its history either

Regulation has its own history within children's social care.

Ofsted did not always regulate children's homes.

Under the Care Standards Act 2000, responsibility initially sat within specialist social care regulation. It passed through the National Care Standards Commission and then the Commission for Social Care Inspection.

On 1 April 2007, responsibility for regulating children's social-care services transferred from the Commission for Social Care Inspection to the newly enlarged Ofsted.

The Commission for Social Care Inspection opposed the transfer, warning that the focus on vulnerable children could be lost inside a much larger organisation dominated by education. It was also concerned about separating the inspection of children's social care from adult social care. Children do not live separately from the circumstances of their families. A parent's mental health, drug or alcohol use, experience of domestic violence or need for adult social care can all affect a child. CSCI had been able to look across those boundaries and at the family as a whole. The new structure divided that responsibility between different inspectorates.

The NSPCC raised similar concerns, and opposition in Parliament questioned whether specialist social-care knowledge and culture could survive the change.

These were not concerns raised after something had gone wrong. They were raised before the transfer.

The Blair government proceeded. The argument was that bringing inspection together would reflect the integration of children's services under *Every Child Matters*, reduce duplication and create a more coherent system.

There may have been an understandable case for bringing inspection of education and children's services closer together.

But what is less clear is why doing so required the children's social care functions of a specialist inspectorate to be absorbed into Ofsted. Integrated inspection was already developing through joint working between Ofsted and the Commission for Social Care Inspection. The choice was not simply between separate services and joined-up inspection. Specialist inspectorates could work together.

Nor did the new structure bring every service affecting children under one inspectorate. Health remained elsewhere. Adult social care remained separate, as did policing, probation, prisons and other parts of the justice system. Local authority governance also sat elsewhere.

The result was not a single inspectorate following the whole child across every part of their life. At the same time, children's social care inspection had been separated from adult social care, despite the extent to which a child's circumstances can be shaped by the needs and experiences of the adults around them.

The question was therefore not whether services should work together or whether inspection should follow the whole child. It was whether institutional merger was necessary to achieve that, and what specialist knowledge and connections might be lost in the process.

The new Ofsted brought together inspection and regulatory responsibilities across education, skills, children's social care and other services affecting children.

But another question followed.

What happened to specialist social care knowledge within a much larger inspectorate whose public identity was overwhelmingly associated with schools?

The concern appeared quickly.

In 2011, the House of Commons Education Committee concluded that having a single children's inspectorate had "not worked well enough to merit its continuation."

It found that the enlarged Ofsted had lost elements of specialist knowledge associated with its predecessor bodies, at senior and operational levels, and remained publicly identified primarily with education.

The Committee recommended dividing Ofsted into separate inspectorates for education and children's care.

That recommendation was not implemented.

Ofsted responded in other ways. It gave social care greater representation at senior level, appointing its National Director for Social Care as a Deputy Chief Inspector. It also changed its approach to child protection inspection, placing greater emphasis on direct inspection of practice and the child's experience, and later began publishing a separate annual report on social care.

But the underlying question did not disappear.

In 2016, the Education Committee again expressed concern about the lack of children's services expertise within Ofsted's senior management. It said Ofsted's social care work was being overshadowed by education and called for stronger senior leadership of children's social care.

But there is another question beneath the concern about social care expertise.

What kind of social care expertise was being recognised?

In 2009, Ofsted reported that 42 of its 44 HMI with a social care background held recognised professional social work qualifications. Only one was recorded as holding a residential work qualification, which Ofsted noted was not recognised as a social work qualification. [211]

That distinction has not entirely disappeared. Ofsted now accepts a Level 5 residential childcare qualification for its Social Care Regulatory Inspector role. But its published requirements for HMI Social Care still require a professional social work qualification and registration with Social Work England.

That matters because residential child care and field social work are not the same work. They have different histories and place practitioners in very different relationships with children. A social work qualification may of course be held by somebody with substantial residential experience. The issue is not the individual inspector. It is which professional qualification the system has chosen to recognise as the route to senior inspection authority.

An experienced residential child care practitioner can qualify for a regulatory inspector role through a residential childcare qualification. But residential expertise alone does not provide a route to HMI Social Care. At that level, the professional gateway remains social work.

The question is therefore not only whether Ofsted retained sufficient social care expertise when regulation transferred from CSCI. It is whose expertise was given authority to define and judge residential child care.

That history matters because Ofsted is not simply an observer of children's social care.

It is part of the system.

It registers providers.

It registers managers.

It inspects children's homes.

It inspects independent fostering agencies.

It inspects supported accommodation.

It interprets regulatory requirements when reaching judgements.

It issues requirements and recommendations.

It can impose conditions.

It can restrict provision.

It can cancel registration.

It can prosecute those carrying on or managing children's homes that should be registered but are not.

And it publishes judgements that influence whether services remain viable.

Those powers have consequences.

Inspection frameworks influence what organisations pay attention to.

Judgements influence what providers believe they have to demonstrate.

Registration decisions influence whether provision opens.

Enforcement decisions influence whether it remains open.

Expectations about leadership influence who becomes a manager and how managers understand their role.

Providers learn what the regulator values.

Regulation does not simply measure a sector. Over time, it shapes the sector it measures.

That makes the regulator's own institutional memory important.

What has Ofsted learned from homes it registered and subsequently judged inadequate?

What has it learned from homes that improved?

What has it learned from providers where quality deteriorated?

What has it learned about management instability?

What has it learned from repeated changes to inspection frameworks?

What has it learned from complaints and challenges to its own decisions?

What has it learned about its own failure to identify abuse?

What has it learned about the consequences of registration delays?

What has it learned about regional variation?

What has it learned about the relationship between regulatory expectations and organisational culture?

And where is that accumulated knowledge when government commissions another review of the workforce?

Ofsted's approach to social care inspection has changed considerably since it assumed responsibility for the sector in 2007.

The 2015 inspection framework for children's homes placed stronger emphasis on children's experiences and progress.

The Social Care Common Inspection Framework subsequently sought greater consistency across different forms of regulated children's social care while recognising their different purposes.

Those changes matter.

But policies introduced in the name of improvement do not erase history.

The same principle should apply to Ofsted that applies to the services it regulates.

Past practice should be examined.

Learning should be visible.

And the consequences of regulatory decisions should be open to scrutiny.

The death of Ruth Perry makes that principle impossible to ignore. [84,85,87,88,89,90]

Ruth Perry was the headteacher of Caversham Primary School, not a residential child-care practitioner.

Her death therefore arose within Ofsted's school-inspection remit.

But its significance extends beyond schools because it concerns the exercise of regulatory authority and an institution's capacity to examine its own practice.

The coroner concluded that the Ofsted inspection carried out in November 2022 contributed to Ruth Perry's suicide.

The findings went beyond the fact that an adverse inspection judgement would inevitably be distressing.

The coroner found that parts of the inspection lacked fairness, respect and sensitivity.

There was an almost complete absence of training or published policy about recognising and responding to severe distress in school leaders.

There was no established provision for pausing an inspection because of that distress.

There was no sufficiently clear route for escalating concerns during the inspection.

And Ofsted had not undertaken a formal learning review following Ruth Perry's death before the inquest.

The coroner was careful not to locate responsibility solely in an individual inspector.

The concern was also with systems, policies and training.

That distinction matters enormously to children's social care.

Residential practitioners are expected to learn from serious incidents.

Registered managers are expected to review practice.

Providers are expected to identify patterns, learn from complaints and demonstrate improvement.

Local authorities are expected to conduct learning reviews.

Inspection itself asks whether organisations learn.

The regulator should be subject to the same expectations.

Ofsted accepted the coroner's findings and introduced changes, including mental health awareness training, a policy for pausing inspections, new routes for those being inspected to raise concerns and an independent learning review of its response to Ruth Perry's death.

That response matters.

But so does the history that made it necessary.

The question is not whether regulation is necessary.

The question is whether inspection without sufficient attention to how regulatory power is exercised can cause harm.

The Ruth Perry case is not evidence about the quality of children's home inspection.

It should not be used as though it is.

It is evidence that the regulator gets things wrong, and of its capacity to learn from failure.

That makes another part of Ofsted's history particularly important.

The growth of illegal children's homes did not happen beyond the sight of the system.

It happened within it.

Local authorities purchased placements in illegal homes.

Courts knew about some when asked to authorise restrictions on children's liberty.

Government knew the problem was growing.

Ofsted knew that increasing numbers of children were living in unregistered settings.

Those carrying on or managing children's homes without the required registration were committing a criminal offence.

And yet the use of illegal homes continued.

Ofsted could investigate suspected unregistered children's homes and prosecute unlawful operators.

But it could not routinely inspect unregistered provision in the way it inspected registered homes.

Local authorities were not required to notify Ofsted whenever they placed a child in an illegal home.

The regulatory system therefore reached an extraordinary position.

Local authorities continued to purchase placements in homes known to be operating unlawfully.

At the Education Committee's Ofsted accountability hearing in January 2025, Yvette Stanley provided an explanation for the limited use of criminal enforcement.

Ofsted had established a small team to investigate and prosecute unregistered children's homes three years earlier, anticipating around 300 cases a year. By January 2025 it was dealing with more than 1,000. Stanley told the Committee that Ofsted was only on its third criminal investigation and that only one case had reached the threshold for prosecution. Criminal investigation, she said, took an extraordinary amount of time.

Stanley told the Committee that where children had been placed through court proceedings, pursuing criminal enforcement could become, in her words, "the state versus the state." She described prosecution as costly and time consuming and said Ofsted had instead focused its energy on moving children and working with local authorities to "get them to a better place." [210]

That explanation matters.

It does not show that Ofsted ignored the problem. It shows something more complicated.

The regulator knew unlawful provision was being used and had powers to investigate and prosecute those carrying on or managing unregistered homes. It could also inspect the local authorities purchasing those placements. At the same time, local authorities were sometimes unable to find suitable registered provision for children they were legally required to accommodate.

Ofsted's own evidence shows that its enforcement decisions were shaped by the system it was regulating.

The shortage of suitable lawful provision, the responsibility of local authorities to accommodate children and the involvement of the courts formed part of the context in which Ofsted decided how to use its enforcement powers.

The relationship between enforcement and the wider system went further. Ofsted's own evidence shows that children were sometimes already living in unregistered homes while providers sought registration. Its registration arrangements developed a priority route for applications where a child subject to restrictions on liberty was already living in an unregistered home.

None of that made the placement lawful. Ofsted's guidance is explicit that a provider must not operate a children's home before registration is granted.

The contradiction became clearer when registration was refused. Ofsted's current inspection framework recognises cases in which a local authority has placed a child with a provider known to be operating unlawfully, including where registration has already been refused.

This was not only a possibility contemplated in guidance. A published tribunal decision records a child being placed in an unregistered home after Ofsted had refused the applications for registration.

That raises a question beyond enforcement delay.

How did a regulatory system reach a position in which Ofsted could decide that a home should not be registered while another part of the state placed a child there?

Its reference to “the state versus the state” is particularly revealing. If a home required registration, the fact that another part of the state had purchased the placement did not alter that requirement.

The question is whether pressures within the system Ofsted regulated should have influenced how an independent regulator enforced the law against those operating unregistered children’s homes.

A court authorising restrictions on a child’s liberty did not make an unregistered children’s home lawful. The court was deciding whether the restrictions on the child could lawfully be authorised. It was not registering or regulating the home.

The criminal offence remained.

That makes it difficult to explain the growth of illegal children’s homes simply through the behaviour of those operating them unlawfully.

The first successful prosecution makes that harder still.

On 4 August 2026, more than two decades after operating an unregistered children’s home became a criminal offence under the Care Standards Act 2000, Ofsted secured its first successful prosecution of an unregistered children’s-home provider.

Catalyst Care Limited and its two directors were convicted in relation to three unregistered homes operating between October 2022 and April 2025. Ofsted said the directors had received repeated warnings that they were breaking the law. Nine children had been accommodated in the homes. [154]

The prosecution showed that criminal enforcement was possible and how rarely it had been used.

For years, local authorities could purchase placements in provision known to Ofsted to be operating unlawfully, while courts sometimes authorised restrictions on children’s liberty within those placements.

Ofsted has now changed its approach. It is expanding its investigative capacity, intends to make greater use of prosecution and is proposing greater scrutiny of local authorities that continue to use illegal provision.

The new power to impose financial penalties gives Ofsted an alternative to prosecution when enforcing the law against those operating unregistered children’s homes.

But doubts about its effectiveness were raised before the power came into force. Ofsted itself acknowledged that some organisations operating illegal homes were making very large sums of money and questioned how much of a deterrent a fine would be.

That makes the absence of previous enforcement more important, not less.

The new power does not explain what happened under the powers that already existed.

For Ofsted, the questions remain.

What did Ofsted know?

When did it know it?

What powers did it have?

Why was criminal enforcement used so rarely?

What choices were made about enforcement?

What did it tell government?

What changed?

What has it learned?

And what happened to the children while those decisions were being made?

There is an even more compelling question.

Who was ensuring that the care those children received was fit for purpose?

The placing local authority remained responsible for the child. Social workers were required to visit and the child's care remained subject to review.

But an illegal children's home sat outside the system of independent regulation that applies to registered homes. It was not routinely inspected by Ofsted.

Ofsted has since acknowledged what that meant. Children living in unregistered homes did not have the regulatory and independent safeguards that apply to registered children's homes, and Ofsted could provide no assurance that they were safe or receiving the care they needed.

Ofsted could investigate whether an unregistered home was operating unlawfully, but investigating an offence is not the same as inspecting the quality of the care being provided.

Nor did a court authorising restrictions on a child's liberty become responsible for regulating the home.

The local authority that placed the child there still had a duty to make sure the child was safe and properly cared for.

If independent inspection exists to provide assurance about the quality and safety of residential care, who was providing that assurance for children living in homes that should not have been operating?

The law is clear about the criminal offence committed by those carrying on or managing an unregistered children's home.

The position of the child placed there raises a different question.

In one case, a 15-year-old girl was placed by her local authority in another unregistered service. While living there, she was sexually abused by two men employed to care for her. Both men were later convicted of offences against her and imprisoned.

She should never have been placed there. The home should not have been operating, and the safeguards attached to registration and inspection were absent.

The crimes committed against her cannot be separated from the fact that a public authority placed her in illegal provision in the first place.

That raises another question.

What redress is available to a child placed in a home that should not have been operating?

Existing routes may include the statutory complaints process, the Ombudsman and, depending on the circumstances, human-rights or civil claims.

But the wider question remains.

What is owed to that child, and are the existing routes to redress sufficient?

There is also a question about the public purse.

When public money has paid for an illegal placement, further public costs follow. They include social-work involvement and, depending on the circumstances, court proceedings, regulation, investigation, enforcement and alternative provision. Where a child has been harmed, further costs can arise through additional services, complaints and legal proceedings.

The Catalyst case makes the contradiction particularly clear.

The three homes had received more than 1.7 million pounds from placing authorities.

Catalyst Care Limited and its directors were fined a total of £92,400, ordered to pay £17,250 in costs and £2,960 in victim surcharges.

Ofsted's published account of the sentence identifies no compensation order for the nine children who had lived in the homes. The victim surcharge does not go directly to them. It contributes to the wider funding of services for victims and witnesses. [154]

On the published information, the first successful prosecution punished the provider but provided no identified direct financial redress to the children who had lived in the illegal homes.

If a public authority is later required to provide financial redress, the public purse pays again.

That is not an argument against redress.

It is an argument for asking how public money came to sustain unlawful provision in the first place.

The question is what the whole failure cost, financially and humanly, and who was accountable while that cost accumulated.

Yet much of the media and campaigning attention focused on providers, the absence of registration, the quality of the accommodation and the money being paid. Some providers charged fees that were difficult to justify in a market where local authorities had few alternatives. Those were legitimate concerns.

But the provider was the most visible part of a wider system.

The local authority that agreed to pay the fee, the shortage of suitable lawful provision and the regulatory decisions surrounding the continued use of that provision were less visible.

Lawful registered providers were operating within that same shortage. They remained responsible for deciding whether they could safely meet the needs of a child being referred and protect the children already living in the home.

A registered vacancy was not necessarily a suitable placement.

Staffing, location, the purpose of the home, the needs of the children already living there and access to health, education and specialist support could all determine whether a vacancy could actually be used.

Regulation mattered here too.

Ofsted's own research found that concerns about inspection ratings were frequently cited by local authorities as a reason why homes rejected referrals for children with complex needs. In 2025, Ofsted changed its inspection guidance to make clearer that providers should not be penalised simply for accepting children with high or multiple needs.

That raises a further question.

To what extent had regulatory pressure contributed to the shortage of suitable registered placements?

That does not establish that regulation caused the growth of illegal provision. But it belongs within the same examination of sufficiency.

Pressure on illegal providers did not create suitable lawful placements.

Closing an illegal home did not create the registered home, workforce, mental-health provision, secure capacity or specialist support the child still needed.

That history is particularly relevant to the present policy direction.

Government intends to expand fostering while using residential care for far fewer children.

If that is the direction of travel, the evidence about why children have already been unable to find suitable lawful residential placements becomes directly relevant.

The answer cannot be found by counting registered beds.

A vacancy that cannot safely meet the needs of the child being referred is not a placement.

The growth of illegal homes therefore raises a difficult question for a policy intended to reduce the use of residential care further.

If the existing system has already been unable to provide enough suitable lawful placements for some children, what evidence demonstrates that reducing the use of residential care will resolve that problem rather than move unmet need somewhere else?

Expanding fostering may provide the right home for children who do not need residential care.

But it does not follow that every child currently requiring residential provision could live successfully in foster care if more foster places existed.

The history of illegal provision makes that distinction difficult to ignore.

If Ofsted expects the services it inspects to learn from failure, the same expectation must apply to Ofsted.

Ofsted has judged the children's social-care sector for almost twenty years.

The evidence should also allow examination of what effect Ofsted's regulation has had on the sector.

Cameron, Gove and another change of direction

By 2010, the diagnosis had changed.

Cameron did not come to power promising to complete Blair's modernisation of public services.

He argued that Labour's approach had itself become part of the problem.

The economy was broken.

Society was broken.

Politics was broken.

More significantly, Cameron argued that government had become too large, too centralised and too willing to assume that another government intervention was the answer.

His alternative was the Big Society.

The idea placed greater emphasis on individual and family responsibility, stronger communities, voluntary action and the transfer of power away from central government.

It was presented as an alternative to an enlarged state attempting to organise social life from the centre.

That matters to children's social care because ideas about the proper relationship between the state, family and community inevitably affect where government believes responsibility for children should sit.

Cameron therefore inherited something Blair had not.

He inherited the system Blair had already reformed.

Much of its architecture remained.

The Coalition did not repeal the statutory arrangements created under *Every Child Matters*. Duties created through the Children Act 2004 remained.

But the explanation of what was wrong changed, and so did the political language around the solution.

The Department for Children, Schools and Families became the Department for Education.

The five *Every Child Matters* outcomes ceased to provide the organising language of central government.

In 2012, the House of Commons recorded reference to a 2010 Department for Education instruction that the language of the five outcomes should no longer be used and that "help children achieve more" should replace it.

Whatever remained of the statutory structures beneath it, the political framing had changed.

That should not be dismissed simply as branding.

Every Child Matters had deliberately described children through five broad outcomes: being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being.

The Coalition placed stronger emphasis on educational achievement, school reform, family responsibility and permanence.

Once again, a new government inherited a system already shaped by previous reforms.

It changed what was emphasised within it.

That matters because language helps determine what becomes visible.

A framework deliberately centred on the whole child asks one set of questions.

A framework increasingly centred on achievement, permanence and particular understandings of family life directs attention somewhere else.

The change was most visible in adoption.

David Cameron made accelerating adoption an explicit government priority.

The 2012 *Action Plan for Adoption: Tackling Delay* sought to reduce the time children waited for adoption and the time prospective adopters waited for approval.

Adoption scorecards were introduced to compare local authority performance and hold authorities to account for delay.

Timeliness thresholds were progressively tightened.

Government sought faster adopter assessment, greater use of national family finding and fewer delays where matching requirements were considered unnecessarily restrictive.

Fostering for Adoption was developed as another route to earlier permanence, allowing children in appropriate circumstances to live with carers who might later become their adoptive parents while the legal process continued.

There was an understandable concern behind these reforms.

Children should not spend unnecessary months or years waiting for a permanent family because systems move slowly.

Delay matters.

Uncertainty matters.

Repeated moves matter.

But the policy also strengthened something that had been developing over several decades.

Permanence increasingly became associated with moving children from care into legally permanent substitute families, particularly adoption.

Adoption transferred parental responsibility to the adoptive family and ended the child's looked-after status.

It also transferred much of the continuing cost of raising that child from the state to the adoptive family.

That was not an accidental consequence.

Government knew the financial effect, measured the savings adoption could produce and presented those savings as a benefit while the reforms were being pursued.

The relevance to the present reforms will become important later.

The family solution has widened.

Where Cameron placed particular emphasis on adoption, the reforms that followed MacAlister have brought kinship and wider family networks much more explicitly into the equation.

But another part of the Cameron era history points in a different direction.

Corporate parenting was not new to the Cameron years.

To understand what changed in 2016, it is necessary to go back much further.

The state had long assumed responsibilities towards children in its care that would otherwise sit with parents.

The Children Act 1948 gave local authorities extensive responsibilities for children in their care and, in some circumstances, powers that amounted to assuming parental rights.

The Children Act 1989 subsequently gave that relationship a clearer legal structure. Where a care order was made, the local authority acquired parental responsibility for the child.

Corporate parenting was therefore not a new idea in 1998 either.

What changed in 1998 was the language.

The Quality Protects programme gave an existing responsibility a name: corporate parenting.

It also made the idea more explicit and more demanding.

The responsibility was not intended to sit only with the social-services department.

The local authority as a whole was expected to act as the corporate parent and to ask whether what it provided to children in its care would be good enough for its own children.

The name was new.

The idea that the state had taken on responsibilities normally exercised by a parent was not.

That distinction matters when we reach 2016.

Government was not inventing corporate parenting.

It was redefining and strengthening an idea that had already shaped children's social care for many years.

In *Putting Children First*, government said that where a child's birth family could not meet their needs, children's social care had a responsibility to create the safe, stable and nurturing relationships and home environment that child needed.

Importantly, it did not restrict that responsibility to one preferred form of care.

It included adoption, foster care, family and friends care and residential care.

For those children, government said, the state became their corporate parent.

Government also proposed putting corporate-parenting principles into law so that responsibility would guide the whole local authority, not only children's social care.

The Children and Social Work Act 2017 subsequently placed those principles into statute.

Local authorities were required to have regard to children's best interests and wellbeing, their wishes and feelings, access to services, high aspirations and the best possible outcomes, stability in their home lives and relationships, education or work, and preparation for adulthood.

That was an important statement of responsibility.

But it raises a question that has received much less attention.

What did the term corporate parent actually mean to the children being parented, and to the adults doing much of that parenting?

Corporate parenting was intended as a statement of responsibility.

The local authority was expected to behave as a good parent would and to ask whether what it provided would be good enough for its own child.

That is an important principle.

But the language can mean something different to the people who grew up in care.

A parent is ordinarily understood through relationship, presence and continuity.

A corporate parent is an institution.

Its representatives change.

Social workers leave.

Managers change.

Placements end.

Services have thresholds.

Support can depend upon age and legal status.

A child can therefore spend years in care without experiencing the organisation described as their corporate parent as a parent in any recognisable relational sense.

Nor will every child want the state understood as replacing their parents or family.

A child can need protection from a parent and continue to love them.

They can be unable to live safely at home while remaining deeply connected to parents, siblings, grandparents and wider family.

The state assuming responsibility for a child does not give it ownership of the child's relationships, identity or sense of belonging.

Corporate parenting is both a promise and a test.

The promise is that the state will accept the responsibilities that a good parent would accept.

But once the state describes itself as the parent, the adults those children become are entitled to judge it against that standard.

What kind of parent moves its child repeatedly because no suitable home can be found?

What kind of parent separates siblings because there is nowhere for them to live together?

What kind of parent places its child somewhere it knows should not be operating?

What kind of parent allows an important adult to disappear from the child's life because the placement has ended?

What kind of parent prepares a teenager for independence at an age when most parents are still providing substantial emotional and practical support to their own children?

And what kind of parent knows little about the adult its child eventually became?

Those questions do not make corporate parenting a bad idea.

They reveal how demanding the promise actually was.

Corporate parenting may therefore be better understood not as a claim to parenthood, but as a promise about responsibility.

And promises can be tested against what actually happened to the children to whom they were made.

But corporate parenting was not experienced only by children.

It also affected how the adults caring for them understood their responsibility.

For many people working in residential child care, parenting a child did not mean replacing their parents.

It meant parenting their child on their behalf for however long, and for whatever reason, that became necessary.

That distinction matters.

Children did not arrive without parents, families, histories or relationships because they entered care.

Parenting them did not require those relationships to be denied or replaced.

It meant caring for them, protecting them, setting boundaries, advocating for them and accepting responsibility for the ordinary and extraordinary parts of their lives while they were there.

That is parenting.

It does not make those adults the child's parents.

It does not erase the child's family.

And it does not give the caregiver ownership of the relationship.

But neither should the system deny the parenting that is taking place because those adults are employed to provide care.

And there is another part of this history.

When local authorities provided much more residential care themselves, the distinction between corporate parent and provider was much less visible.

The same local authority held responsibility for the child, owned the home and employed the adults providing the daily care.

Those adults were not the corporate parent in law.

They worked within the organisation that was, and they were among the people through whom its parenting responsibilities were exercised every day.

As care increasingly moved into independent organisations, those functions separated.

The local authority remained the corporate parent.

The organisation caring for the child became the provider.

The people providing the daily care became the workforce.

The parenting did not stop.

But the language increasingly separated it from the people doing it.

In effect, the independent provider was reduced to the role of a paid babysitter: responsible for the child's day-to-day care, but without the authority or recognition of a parent.

Residential child care is not babysitting.

A babysitter cares for somebody else's child for a limited period while the parent remains elsewhere.

A child may live in a children's home for years.

The adults employed there may wake them for school, cook their meals, know when something is wrong, sit with them when they cannot sleep, attend school meetings, take them to hospital, manage crises, celebrate birthdays, set boundaries, repair arguments and share the ordinary events through which relationships are formed.

Calling the local authority the corporate parent does not change who is there when the child wakes in the night.

Nor does describing an organisation as a provider alter the nature of what it is being paid to provide.

As the mixed economy developed, the language became increasingly administrative.

The organisation became a provider.

The child became a referral.

The process became an auction.

The home had capacity, vacancies and occupancy.

The child had somewhere to live.

The placement was purchased.

The fee increasingly became the principal measure through which the relationship between commissioner and provider was discussed.

Those terms have administrative meaning.

But they can obscure what is actually being purchased.

A home.

Care.

Relationships.

And adults who accept responsibility for a child every hour of every day that the child lives there.

None of this means that an independent provider holds the same statutory responsibility as the local authority.

It does not.

Nor should the language of parenting protect providers from scrutiny over quality, safeguarding, fees or profit.

It should not.

The question is what happens when a necessary legal distinction becomes a relational one.

The local authority can retain the title of corporate parent while becoming increasingly distant from the child's daily life.

The provider can carry extensive responsibility for that daily life while increasingly being treated as a contractor delivering a purchased service.

And the people building the relationships with the child can sit outside the language of parenting altogether.

Perhaps that is part of what was lost as care became increasingly separated into commissioner, provider, placement and workforce.

The language became clearer about who held the legal responsibility.

It became less clear about who was actually doing the parenting.

That separation becomes particularly important when things go wrong.

The corporate parent can say that the provider delivered the care.

The provider can say that the local authority made the placement and retained responsibility for the care plan.

The regulator can judge whether the provider complied with regulation.

The commissioner can decide whether to continue purchasing.

The child does not experience those responsibilities separately.

They experience the adults and organisations around them as one care system.

And their understanding of who actually cared for them may be quite different from the system's description of who held responsibility.

The adult they later regard as having parented them may be a foster carer.

It may be somebody who worked in a children's home.

It may be a grandparent, sibling or another member of their family.

It may be somebody the formal system barely recognises once the placement has ended.

A statutory designation cannot decide who mattered to the child.

Nor can it decide who will still matter when that child becomes an adult.

That raises questions for those who did the caring too.

Did they understand themselves as delivering a service, or as adults accepting a parenting responsibility towards a child?

What happened when a relationship formed through years of daily care was expected to end because the placement ended?

And how did a system that expected adults to form meaningful relationships with children come, at different points in its history, to regard the continuation of some of those relationships as a professional or safeguarding concern?

Those questions belong to the later discussion about enduring relationships.

But their roots are here.

Corporate parenting also raises a more fundamental question about placement policy.

Who is actually parenting the child?

Corporate parenting begins with what the child needs from the state.

A placement hierarchy begins with what the state wants the child's placement to be.

The state is the corporate parent. Therefore, the question should begin with what a good parent would want and do for this child.

For some children that may mean returning safely to family.

For others it may mean adoption, kinship care or fostering.

And for some it may mean residential care.

The responsibility of the corporate parent does not become smaller because the child needs a children's home.

The Cameron years therefore belong in this history for more than one reason.

They changed the language inherited from *Every Child Matters*.

They introduced the Big Society as a wider political argument about the balance between state, family and community.

They accelerated the adoption agenda.

They strengthened performance measurement around adoption and the speed with which it happened.

And they continued the longer movement towards family placement as the preferred solution for children who could not remain with their birth families.

The House of Lords Adoption Legislation Committee subsequently identified the limitation.

The new scorecards measured timeliness.

They did not provide equivalent information about the quality or long-term stability of the resulting placements.

More fundamentally, the policy emphasis had moved away from the wider meaning of permanence found in the research.

Permanence was about security, stability, continuity, belonging and relationships that endured. The research identified different ways of achieving it, including sharing care with a child's family.

It did not define permanence as replacing one family with another.

Yet adoption increasingly became the route through which government talked about, measured and pursued permanence.

Speed was measured. Long-term stability was not.

That distinction matters. An adoption order records a legal outcome. It does not, by itself, tell us what happened to the child afterwards, whether the placement endured, whether the relationship survived or whether the child later returned to care.

Adoption breakdown was not a rare or insignificant occurrence. The problem was that government did not reliably know how often it happened.

In 2012 the Department for Education told the House of Lords that there was no regular and consistent national measure of adoption breakdown. The research available at the time produced widely differing estimates, with substantially higher rates for some groups of children, particularly those adopted at an older age. [57]

The Department's own later research demonstrated the same problem. Administrative records produced a relatively low rate of recorded post-order disruption, while surveys of adoptive parents found that 8 to 9 per cent of children had left their adoptive homes prematurely. The researchers concluded that an exact disruption rate could not be established. [188]

That distinction matters. A low figure produced from administrative records should not be allowed to turn an inadequately recorded problem into a rare one.

The later Family Routes study does not resolve that problem. It can identify children who were recorded as returning to care after adoption where the necessary records can be linked. But that is not the same as identifying every adoption that failed. A child may return to care with the immediate reason recorded as family under acute stress, family dysfunction or another category. The child is visible as entering care, but the history that this followed the breakdown of an adoption depends upon the earlier adoption being identifiable and successfully linked. [98]

Family Routes itself found hundreds of recorded adoption disruptions that could not be linked to an adoption order in the social-care datasets and therefore could not be included in its disruption analysis. [98]

Nor does a child who does not return to care necessarily represent an adoption that succeeded. An adoptive relationship can break down without another care episode.

Not returning to care is not the same as an adoption having succeeded. Nor is it evidence, on its own, that permanence endured.

Government therefore knew enough to know that some adoptions failed, but it was measuring how quickly children reached adoption before it had a reliable way of measuring what happened afterwards.

The significance of these developments lies in their cumulative effect.

A policy that moves more children more quickly into adoption changes who remains in care and, where those placements subsequently break down, who returns to care.

A policy that expands fostering changes the population again.

And a policy that subsequently describes residential care as appropriate for only a smaller and more specialised group is building on the consequences of those earlier decisions.

Policy does not simply respond to the population in residential care.

Over time, policy helps create that population, including who remains in care and who returns to it.

If successive policies have already moved children towards family placement for decades, what evidence now demonstrates that another substantial shift in the same direction will produce better outcomes?

From Teach First to Frontline

Josh MacAlister entered teaching through Teach First.

He then founded Frontline.

When Frontline was launched in 2013, government explicitly connected it to the Teach First model. Andrew Adonis became its chair. [58,64,158]

Frontline was not simply another route into social work.

It sought to attract different recruits, train them differently and develop leadership.

That leadership ambition matters. The people developed through a new professional route did not necessarily remain at the point where they entered the profession. They could move into positions from which they shaped organisations, influenced policy and led further reform.

And government was prepared to spend significantly more on it.

When the House of Commons Education Committee examined social work reform in 2016, it found that the gross public cost per Frontline participant was approximately three times that of the undergraduate route. The Department produced a lower comparative figure after taking wider economic benefits into account, but the Committee still called for longer-term comparative evaluation.

Government was therefore not simply buying a cheaper route into social work.

It was investing in another model of professional formation.

That raises a useful question.

What was government buying?

It was buying another route into social work.

But it was also investing in another mechanism through which change could enter the profession.

Frontline carried an approach first associated with education reform into children’s social care.

Influence travels too

The earlier history shows how practice and professional assumptions can travel through people and organisations.

The recent reform history raises a related question.

How does influence travel?

Joe Hanley, Robin Sen, Caroline Bald, Christian Kerr and Calum Webb approached this through their network mapping of children's services. [91]

Their work brought together around a thousand publicly verifiable connections involving people and organisations across government, charities, private organisations and children's services.

The significance of the map can easily be misunderstood.

A connection does not establish wrongdoing.

It does not demonstrate that people hold identical views.

Nor does movement between organisations make somebody compromised.

Its value is that it makes something normally difficult to see visible.

People move.

Relationships move with them.

Knowledge travels.

Ideas travel.

Professional language travels.

Ways of defining problems travel.

And influence can travel too.

That has an important historical parallel.

Pindown showed how practices could move through professional relationships and organisations.

The later reform history shows how ideas about how systems should be changed can move through professional and political networks.

There is a line worth examining from Blair and Adonis, through Teach First and Frontline, to the current children's social-care reform. But it is not a simple line of continuity.

The first Labour government since the Blair and Brown years is now reforming significant parts of a system that those earlier Labour governments inherited and progressed.

The direction of reform may change, while the belief in structural reform, and the methods used to deliver it, remain.

There is an economic question running through this history too.

Who puts the money in, who provides the service, who carries the financial risk, and who takes money out?

Those relationships have changed repeatedly as provision has moved between public authorities, voluntary organisations and private providers, and as government has changed the way services are commissioned and funded.

What has been learned from previous reforms before the taxpayer is expected to pay again?

The question is not whether influence should travel.

Of course it does.

The more important question is whether challenge travels with it.

That is the distinction between examining how influence travels and claiming that relationships determine policy.

Influence is inevitable.

Independent challenge is not.

When influence meets evidence

The network map does not show that relationships determine policy. It makes connections and movement visible.

The question becomes more significant when people, organisations and ideas within connected reform networks move between diagnosing a problem, designing a solution, producing or selecting evidence, advising government and participating in implementation.

That is where influence and selective research meet.

Political manipulation does not require evidence to be fabricated. Evidence can be accurate and still be used selectively.

A review can consult widely and still begin from a narrow frame. A piece of research can be methodologically sound and still be asked to carry a policy conclusion it did not establish. An independent evaluation can be commissioned to answer a question about implementation without asking whether the policy itself should continue.

The relevant questions are straightforward.

Who defined the problem?

Who framed the research question?

Which evidence was selected to support the diagnosis?

What evidence pointed in another direction?

Who selected the experts and organisations given authority to interpret it?

Could the evidence change the policy?

And what would happen if it did?

Transparency about those decisions is not an accusation of conspiracy. It is a safeguard against political opinion becoming policy certainty.

From Frontline to the Independent Review

MacAlister subsequently moved from founding Frontline to leading the Independent Review of Children's Social Care. [76,77]

The reform method travelled.

The review was commissioned in 2021 and reported in 2022.

Its remit was much wider than residential care.

But it made recommendations that would substantially alter structures, commissioning, workforce development and where authority sat within children's social care.

It proposed Regional Care Cooperatives covering fostering, residential and secure care.

It proposed major changes to family help and support for family networks.

It recommended professional regulation of the residential child-care workforce, beginning with children's home managers.

It proposed a new leadership route for children's home managers, including the recruitment of high-potential people into those roles.

It proposed new standards across forms of care.

And its proposed direction would see residential care increasingly focused on highly specialised provision for children considered to have the greatest needs.

These were not minor adjustments.

They were another attempt to reorganise structures, professional routes, leadership and authority.

The resemblance to the earlier reform method is difficult to ignore.

Blair and Adonis had developed an approach in which new structures, professional routes and leadership pipelines became instruments of reform.

Teach First embodied it.

Frontline carried it into social work.

The longer-term consequence is now visible. A route created to bring new people and new thinking into public services also helped create people who would later acquire authority to define problems, lead reviews and shape the next generation of reform.

The Independent Review carried many of the same assumptions into the redesign of children's social care itself.

That does not make the proposals wrong.

It means they have a history.

And that history should have been capable of challenging them.

The assumptions behind the reform

There is another history that needs to be examined here.

It is the history of the assumptions behind the present reform programme.

Josh MacAlister's professional route into children's social care began through Teach First rather than through residential child care, fostering or statutory social-work practice. He taught for approximately three and a half years. Published accounts of his career identify his contact as a teacher with pupils who had experience of care as the point at which he began thinking about children's social work.

That experience was real.

It was also particular.

Seeing children who have experienced care from the classroom is not the same as knowing the care journey that brought them there.

MacAlister subsequently acquired substantial experience of social-work reform and leadership through Frontline.

But that is different from asking whether the beliefs that informed later reform were adequately tested against evidence capable of challenging them.

When the Independent Review of Children's Social Care was launched in 2021, the public language already emphasised stable, loving homes and extending the love and security of family life to children who could not remain with their birth families.

Those aspirations are understandable.

But they also contain assumptions about the nature of the problem and where the answer is likely to be found.

Five years later, government policy places increasing emphasis on family networks, substantially expanding fostering, reducing the use of residential care and making enduring relationships a central organising principle.

None of those propositions is self-evidently wrong.

But neither should they be treated as self-evidently right.

The question is where they were tested.

More than fifty years ago, research into drift and permanence had already established the importance of continuity, belonging and lasting relationships.

Permanence planning developed partly in response to children remaining in care without clear plans, enduring relationships or a secure sense of where they belonged.

What followed was decades of permanence planning, family finding, adoption reform, long-term fostering, statutory reviewing and later policies intended to extend support into adulthood.

The young adults whose deaths are now being examined therefore grew up within a system in which permanence had been an established policy objective for generations.

On 25 August 2026, Ashley John-Baptiste and Clare Chamberlain published *'You Really Are on Your Own': A Study of the Early Deaths of Young People Who Were in Care*. The review considered 112 notifications made to the Department for Education during 2025 concerning the deaths of care leavers aged 18 to 24. It identified being alone, the loss of relationships and the sharp reduction in support at the transition to adulthood as important themes. [142,156]

Those findings matter.

But identifying loneliness and isolation among young people who died is not the same as establishing loneliness as a cause of their deaths.

The review could identify a pattern. It could not establish that loneliness was a leading cause of death.

There is another body of evidence that demonstrates why that distinction matters.

Children who enter care are part of a much wider population of children who experience significant childhood adversity. Entry into care is often not the beginning of that adversity, and children who experience similar adversity do not all enter care.

Benjamin Perks has spent much of his career working internationally on children's rights and child protection through the United Nations and UNICEF. He also spent part of his own childhood in children's

homes. In his 2015 TEDx talk, *How Do We Stop Childhood Adversity from Becoming a Life Sentence?*, he drew attention to research on adverse childhood experiences and their association with later outcomes. [199]

During the talk he used an extract from the short film *ReMoved*, which follows a girl from an abusive home into foster care. [200]

The film is not research evidence.

It makes the chronology visible.

The child does not arrive in care without a history.

What happens after she enters care cannot be understood without knowing what happened before she arrived.

Research into adverse childhood experiences has found associations between childhood adversity and poorer outcomes later in life, including premature mortality. [201]

But that evidence has limitations too.

ACE research operates principally at population level. An ACE score brings very different experiences together, does not necessarily reflect their severity, frequency, duration or timing, and can obscure poverty, inequality and other social and structural influences. It cannot predict the outcome of an individual life. [202]

Association is not causation here either.

The ACE evidence therefore does not provide an alternative explanation for the deaths of people who have been in care.

It shows why the inquiry had to remain open to other explanations and to the interaction between them.

What happened before care, what happened during care, what happened after care, and how did those experiences interact across the life course?

So does the order in which the policy and the review developed.

When the review was announced in April 2026, government said its learning would feed into the forthcoming Enduring Relationships Programme. Before the review had reported, the Enduring Relationships strategy had been published. It said the reviewers had been asked to examine whether loneliness arising from repeatedly failing relationships was a leading cause of early death. [137,156]

The review then identified being alone, the drop in support at transition and the workforce supporting that transition among its principal learning themes.

Those findings may be valid.

But finding evidence consistent with an explanation is not the same as testing that explanation against the alternatives.

The independence of the reviewers is not the same as the independence of the inquiry.

The question is what the commission itself was at liberty to discover.

If some nevertheless reached adulthood profoundly alone, the historical question is not whether we have only now discovered that relationships matter.

We already knew that.

The question is what happened to what we already knew.

Did permanence become too closely identified with achieving a placement or legal outcome rather than asking which relationships actually endured?

Did children lose important relationships when they were moved in pursuit of another placement considered more permanent?

Did repeated attempts to achieve family placement increase instability for some children?

Did professional boundaries prevent relationships with previous caregivers continuing?

Did the move into adulthood end relationships created through the care system precisely when young people still needed them most?

And did the system stop following the child once the administrative outcome had been achieved?

These questions do not reject permanence.

They test what permanence actually produced.

They also test something more fundamental within the present reform programme.

The belief that children need stable, loving and enduring relationships does not require further proof.

The difficult question is whether the policies being pursued in the name of those relationships actually produce them.

A preference for family care is not evidence that repeated attempts to achieve family placement will create greater relational permanence for every child.

The question is not simply what evidence supported the diagnosis.

It is what evidence was allowed to put the diagnosis itself at risk.

Permanence does not end the journey

Adoption provides another example of why administrative outcomes need to be followed beyond the point at which they are achieved.

Its history stretches through mother and baby homes, permanence planning and family finding.

Adoption is intended to create a permanent legal family and end a child's journey through care.

The Adoption and Children Act 2002 substantially changed the legal framework. [35]

The earlier discussion of the Cameron years shows why the administrative outcome cannot be treated as the whole story. Government measured how quickly adoption happened before it had a reliable way of measuring adoption breakdown, and later research remains constrained by what administrative records can identify. [57,98,188]

An adoption order ends the child's looked-after status. It does not necessarily end the child's need for care or support.

Some adopted children later return to care. Others continue to need substantial support without returning to care.

Adoption removed children from the care statistics. It did not necessarily remove their need for care.

A child entering foster care has not reached the end of the story.

A child entering residential care has not reached it either.

Policy needs to follow what happens next.

When relationships became a risk

There is another part of this history that the present emphasis on enduring relationships cannot avoid.

The residential abuse scandals of the late twentieth century exposed profound failures.

Children had been abused by adults who exploited relationships of trust.

Organisations had failed to identify grooming.

Children were not believed.

Management, supervision and scrutiny failed.

Every child arrives with a story.

Some of it is known.

Some of it is recorded.

Some of it may have been misunderstood.

And some of it may not yet have been told.

Adults have to be able to recognise the story a child is unable to tell.

What a child is living through, has lived through or remembers may be revealed through behaviour, fragments of information, changes in relationships, fear, anger, withdrawal or things said that do not initially appear to be telling us what happened.

Children do not always say plainly what has happened to them.

Adults therefore have to do more than wait for them to tell.

They have to notice.

They have to listen.

They have to remain curious about what they are seeing and hearing.

So, the question is not simply whether children tell.

It is how we help them to tell their story, what we see, what we hear, and how we create the conditions in which they are able to share it.

Whether they are believed, how adults respond, what is recorded and what happens next can determine whether that story continues to unfold or closes down again.

Safeguarding had to change.

Recruitment became more rigorous.

Vetting improved.

Allegations procedures strengthened.

Professional boundaries received much greater attention.

Adults caring for children were expected to understand how power, dependency and intimacy could be misused.

Those changes were necessary.

As with care and control, professional boundaries were easier to require than to define.

There was guidance, but what those boundaries meant in the relationship between a child and caregiver was not always clear.

Organisations developed their own policies and workers had to interpret what was expected of them.

That uncertainty mattered.

In parts of residential care, closeness itself became something about which adults were expected to be cautious.

Physical affection could become a safeguarding risk.

That concern did not disappear with the period in which it developed. NICE's 2021 evidence review found concerns among both foster and residential carers about physical touch and affection because of fear of allegations. Its committee concluded that appropriate physical affection could be an important source of emotional stability and wellbeing and might sometimes need to be actively encouraged within safer caring plans. [193]

Workers learned to consider not simply what a frightened or distressed child might need from them, but how an action might later be interpreted.

Affection itself could therefore become something to regulate.

There was an era of carefully managed affection.

The side hug became symbolic of it.

Restricted forms of physical contact, of which the documented 'side-hug' culture is one example, could be regarded as safer than ordinary physical affection. [167,168]

This was not one national rule instructing every residential worker how to hug a child.

It was something more significant.

A safeguarding culture developed in which ordinary expressions of affection could become professionally suspect.

And that culture did not remain within residential care.

It travelled into fostering.

Foster carers too became concerned about allegations, physical affection and the boundaries between parenting and professional care.

Guidance could warn carers about touch.

Men could be particularly cautious about physical affection.

The foster home might be described as a family environment while the adults within it were simultaneously expected to think about affection through a safeguarding and professional-risk lens.

The contradiction is important.

The system wanted children to experience family life at the same time as expecting the adults providing it to behave differently from parents.

The problem went beyond physical affection.

It affected relationships themselves.

A child could live with a foster carer for years and never be hugged.

A residential worker could care for a child and still be left to interpret where the professional boundary lay.

Yet relationships developed through ordinary life.

Getting up for school.

Meals.

Arguments.

Hospital visits.

Birthdays.

Family contact.

Returning after going missing.

Success.

Failure.

Fear.

Repair.

The child moved.

And the relationship could be expected to end because the placement had ended.

Former foster carers could find continued contact discouraged.

Residential workers could find that maintaining relationships with young people after they left conflicted with organisational policies or professional-boundary expectations.

Where continuing contact was prohibited, a worker who maintained it could place themselves in breach of organisational policy.

The caregiver might want the relationship to continue.

The child might desperately want it to continue.

But the organisation that had brought them together could decide that continuing it presented risk.

What the child experienced as a relationship was understood by the organisation as part of the placement.

When the placement ended, the professional responsibility ended.

The expectation was that the relationship ended with it.

Some relationships continued outside the knowledge of the system.

Others were lost and re-established years later.

That distinction matters enormously.

A residential worker might have cared for a child for several years.

Sat beside them in hospital.

Known what frightened them.

Known their family.

Known how they behaved when they were anxious.

Stayed through rejection and anger.

Been the person the child came to when everything else went wrong.

Then the child moved.

The worker might want to remain in their life.

The child might want them to remain.

But a relationship that had been regarded as evidence of good care while the placement existed could become a professional-boundary concern once the placement ended.

Safeguarding began from a necessary question:

How do we protect children from adults who misuse relationships?

In some places the answer travelled towards something different:

Maintain professional distance. Restrict physical affection. Be cautious about closeness. Be suspicious of relationships that continue beyond the professional task.

That may have made organisational boundaries clearer.

It did not necessarily make children safer from the effects of repeated loss.

So what changed?

Staying Put marked an important shift. [164]

Its underlying principle is that a foster relationship should not necessarily end because the young person turns 18.

The legal foster placement ends.

The relationship does not have to.

Staying Close extends a related principle to residential care. [137,166]

Leaving a children's home does not mean losing the people associated with it.

A relationship formed within a regulated placement can now legitimately cross the boundary between care and leaving care.

Government's present *Enduring Relationships* policy moves further still. [137,163]

The policy emphasis has shifted. Professional boundaries remain necessary, but relationships are increasingly recognised as something children also need to be protected from losing.

That is a significant change.

So, the historical question has to be asked:

What has changed?

Children have not changed.

Children have not suddenly begun needing physical affection.

They have not suddenly begun needing somebody to remain after a placement ended.

They have not suddenly begun needing people who know their history.

Bowlby, Winnicott and later permanence literature placed continuity and relationships at the centre of child-care thinking generations earlier.

What changed was the system's judgement about the risks of closeness and the risks of separation.

For a period, safety could be pursued through professional distance.

Now government increasingly recognises that the loss of relationships can itself cause harm.

What has received much less examination is what happened during the period in between.

How many significant relationships ended because a placement ended?

How many foster carers were discouraged from remaining?

How many residential workers were told they should not remain in a child's life?

How many children understood that somebody cared for them only to discover that the relationship belonged to the service rather than to them?

How many relationships were prevented from developing because caregivers were frightened of allegations?

And what did repeated endings contribute to the loneliness government now identifies?

Before government criticises the care system for failing to create enduring relationships, it needs to investigate what previous policy and safeguarding practice did to the relationships children had already formed.

The last resort

There is another contradiction within the present language.

Government describes the need for *loving homes in family settings* while describing residential homes through the language of purpose and specialism.

The distinction is revealing.

Family care is described through love. Residential care is described through function.

Yet fostering and residential care both passed through the same period of anxiety about closeness, affection, allegations and professional boundaries.

Foster carers became frightened of hugging children.

Residential workers were reduced to side hugs.

Relationships with former foster carers were broken. [161]

Relationships with residential workers were prohibited after children moved.

It is therefore difficult to sustain an account in which love naturally belongs to family care while residential care is principally a professional intervention.

The relevant question is not whether the placement is called foster care or residential care.

It is:

What did the child experience in the relationship?

A foster family can provide profound love and lifelong belonging.

A residential worker can become somebody who remains in a person's life for decades.

A foster placement can be emotionally cold, controlling or abusive.

A residential placement can provide affection, safety and relationships that endure.

The category cannot tell us which occurred.

Enduring does not mean safe

There was good reason for safeguarding to become concerned about relationships.

Children have been groomed and abused by adults whom they trusted.

A child can feel intensely attached to somebody who is harming them.

Dependency can be used to maintain control.

Affection can coexist with coercion.

That means contemporary policy has to avoid making the opposite mistake.

An enduring relationship is not necessarily a safe relationship.

Neither is a stable placement necessarily evidence of good care.

A placement may endure because a child feels loved, secure and belongs.

It may also endure because the child is dependent upon the caregiver.

Because they are frightened.

Because they cannot imagine another place to go.

Because they believe nobody will believe them.

Because compliance has become the price of maintaining the relationship.

Or because dependency and coercive control have become embedded within it.

A placement can therefore be recorded as stable for years while the relationship within it is profoundly harmful.

And a relationship can continue into adulthood without that endurance proving that it was healthy.

Placement stability is not the same as relational permanence.

And:

Relational permanence is not necessarily evidence of relational safety.

The old system risked assuming:

closeness is dangerous.

The new system must not assume:

closeness is protective.

Relationships can protect children.

Relationships can also be the means through which children are controlled and harmed.

The safeguarding question therefore has to become more sophisticated.

How do we help safe relationships endure while recognising and interrupting unsafe ones?

Who decides?

There is an even more fundamental question beneath the language of enduring relationships.

Who decides whether a relationship should endure?

The child?

The caregiver?

Or the system that brought them together?

None can decide alone.

The child's wishes and feelings must be central.

But a child can value a relationship that is exploitative, controlling or abusive.

A caregiver cannot claim a continuing relationship simply because they believe it matters.

The child may no longer want it.

And the system cannot assume ownership of a relationship simply because it originally arranged the placement, approved the foster carer or employed the residential worker.

The system may bring two people together.

That does not mean the system owns the relationship that grows between them.

The child should have the strongest voice in identifying who matters.

The caregiver must freely choose whether they are willing and able to remain.

The system's role should be to protect children from genuine safeguarding risk and enable safe relationships to continue, not to declare that a relationship ends simply because its administrative purpose has ended.

If both the child and caregiver want the relationship to continue and there is no evidenced safeguarding reason why it should not, why should the presumption be that it ends?

And if the system believes it is unsafe, the decision should be based upon identifiable risk rather than general anxiety about closeness, professional boundaries or organisational discomfort.

The issue becomes even more complicated at 18.

At 17, the local authority may decide that contact with a particular former caregiver should not occur.

At 18, the young person is legally an adult and may decide to establish that relationship for themselves.

What changed overnight?

Not necessarily the young person.

Not necessarily the caregiver.

The authority of the system changed.

That exposes the difficult boundary between safeguarding responsibility and a person's right to choose their own relationships.

Who owns the liability?

There is another reason the system may have preferred clear professional boundaries.

Who carries the responsibility if a continuing relationship goes wrong?

While a child lives in a children's home, the relationship between worker and child exists within a regulated service.

There is an employer.

Supervision.

Policies.

Management responsibility.

Inspection.

Safeguarding procedures.

A similar framework exists around foster care.

Then the placement ends.

Suppose the relationship continues.

A former residential worker meets the young person for dinner.

The young person goes to their home at Christmas.

They telephone when something goes wrong.

The former worker becomes someone they describe as family.

Where does the professional relationship end and private life begin?

Who supervises it?

Who assesses risk?

When does the provider's responsibility end?

What responsibility remains with the local authority?

And if harm occurs, who is accountable?

Those are not reasons to prevent the relationship.

They are reasons why the policy needs to answer the question.

From an organisational perspective, there is obvious attraction in a simple rule:

when the placement ends, contact ends.

The organisational boundary is clear.

The employment relationship remains clear.

Liability is easier to understand.

But what protects the organisation may cost the child another significant relationship.

Safeguarding and organisational risk therefore need to be distinguished.

Protecting children from unsafe adults is not the same thing as protecting organisations from uncertain liability.

Current government policy explicitly asks relationships to continue across boundaries that once marked the end of formal responsibility.

Staying Put crosses the eighteenth birthday.

Staying Close crosses the boundary between residential care and leaving care.

Enduring Relationships envisages adults remaining within children's lives well beyond the placement in which they first met.

That may be exactly what some young people need.

But the relationship does not cross those boundaries alone.

Risk crosses them.

Responsibility crosses them.

And potentially liability crosses them.

Government therefore needs to answer:

Who owns the relationship?

Who owns the risk?

Who owns the responsibility?

And who owns the liability when something goes wrong?

The answer cannot be to prohibit relationships simply because liability is difficult.

Nor can government encourage enduring relationships while leaving responsibility for their safety undefined.

If policy asks relationships to endure beyond placements, safeguarding and accountability must be capable of enduring with them.

Otherwise, risk aversion may eventually take the system back to where it began.

Start with the relationships that endured

There is another source of evidence that has received too little attention.

The relationships that actually endured.

Some adults who spent time in care as children remain in contact with foster carers, residential workers, social workers, teachers and other adults who cared for or knew them decades earlier.

My own experience includes relationships with people I cared for as children that continued after the placement ended. I do not offer those relationships as proof of a model. They are one reason I ask why some relationships endured despite professional and organisational boundaries while others were ended by them.

Those relationships deserve examination.

They tell us something placement statistics cannot.

A placement can end and the relationship continue for life.

Conversely, a placement can be recorded as stable for years and leave no relationship that survives it.

More importantly, a placement can be recorded as stable for years while the relationship within it was based upon dependency, coercive control or abuse.

Duration alone tells us very little.

But where a safe relationship survives the end of the placement, the end of payment, the end of statutory responsibility and sometimes the end of the caregiver's employment, something important has occurred.

The system no longer requires the relationship.

The former child is no longer required to participate in it.

The caregiver no longer has a professional duty to remain.

If both continue to choose the relationship, we should want to understand why.

Not because endurance proves that the care was good.

It does not.

But because those relationships may tell us more about permanence than the administrative outcome ever could.

A placement outcome can be counted.

An adoption order can be counted.

A long-term foster placement can be counted.

A Staying Put arrangement can be counted.

The closure of a residential placement can be counted.

The person who is still there twenty, thirty or forty years later is much harder to count.

Yet that may tell us something far more important about what permanence actually meant.

We should ask the adults children became.

Who remained?

Why that person?

What had they done when the child was young?

Who maintained contact?

Did anybody try to prevent the relationship?

Did the caregiver take a professional risk by remaining?

How did the relationship change as the child became an adult?

Could the adult disagree with the former caregiver?

Could they leave?

Could they establish other relationships?

Did the caregiver support independence or preserve dependency?

Was the continuing relationship freely chosen by both?

Did it provide somewhere to return without restricting the adult's ability to move forward?

And looking back now, what does the adult say that relationship meant?

The same questions should be asked of relationships that did not survive.

Who disappeared?

Why?

Did the child want them to remain?

Did the caregiver?

Did policy stop them?

Did an employer?

Was contact ended because another placement was intended to become permanent?

Was it ended for a legitimate safeguarding reason?

Or did it end because professional practice assumed that relationships belonged to placements?

Those are empirical questions.

And they could tell us considerably more about enduring relationships than beginning with another model of what government thinks such relationships should look like.

If we want to understand enduring relationships, start with the relationships that endured.

Investigate the relationships that did not.

Investigate the relationships the system broke.

Investigate the relationships that became unsafe.

And ask the adults children became what those relationships meant.

Follow the child.

Follow the relationship.

Follow both into adulthood.

What changed?

Fostering is the right form of care for many children.

But fostering has also been the dominant placement for more than four decades.

That matters when government now proposes substantially more of it as the means through which residential care can be used for far fewer children.

This is not an untested direction.

It has been the direction of travel for more than forty years.

Sir Martin Narey's 2016 review is particularly important.

Its remit explicitly placed residential care within the wider care system.

Narey broadly welcomed the historical move towards fostering.

But he found very little scope for reducing reliance on children's homes further.

His conclusion was clear:

"I see very little scope for reducing our reliance on children's homes and I am quite clear that to do so would not be in the interests of children." [63]

He also challenged the idea that children's homes should automatically be treated as placements of last resort and identified circumstances in which residential care might be considered earlier.

Ten years later, government says residential care should be used for far fewer children. [2]

That creates an obvious evidence question.

What changed between Narey's conclusion in 2016 and government policy in 2026?

There may be new evidence.

If there is, it should be visible.

The policy preference for family life has too often allowed fostering itself to be romanticised. A preference for family life is not evidence that every child can be successfully cared for in a foster family, nor does it remove the need to examine the professional, financial and organisational system through which modern fostering is delivered.

Creating more foster care places does not itself establish that fostering can substitute for residential care for children who need it.

Children do not arrive in residential care without a history

Ofsted's study of children entering children's homes helps explain why that matters.

Of the 52 children in its study whose original plan had not been residential care, 31 entered a children's home following foster placement breakdown.

Of those 31, 28 had experienced three or more previous fostering breakdowns.

Around three quarters of the children in the study were subsequently considered well matched to the children's home in which inspectors found them. [78]

That does not tell us that every one of those children should have entered residential care earlier.

It does tell us that residential care cannot be understood by looking only at what happens after the child arrives.

A child may enter care already carrying abuse, neglect, loss or instability.

A foster placement ends.

Another relationship is lost.

Perhaps a school changes.

Another placement begins.

That ends too.

By the time residential care is finally considered, the child may be described as having highly complex needs.

The NICE evidence review adds an important dimension to this. In one of the studies it considered, young people themselves described changes of placement as closely associated with self-harm, through the loss of relationships, support and control over their lives. For some, self-harm followed a move. For others, self-harm contributed to another placement ending. [193]

And what is later described as mental-health difficulty may itself have a history.

Repeated breakdown does not simply reveal need.

It adds to it.

This is why the boundary drawn around the present workforce review is so difficult to understand.

The workforce receiving children after repeated foster placement breakdown is being reviewed.

The fostering system through which some of those children travelled is not.

Instead, expanding fostering sits outside the review as part of the policy answer.

If government believes that expanding fostering will allow residential care to be used for far fewer children, the evidence for that assumption belongs inside the same review.

The BERRI evidence used in the government's national fostering strategy is also travelling into implementation. Greater Manchester's 2026–27 Regional Care Cooperative delivery plan includes a six-month BERRI pilot involving up to 100 children, including children in high-cost placements, children with multiple placement disruptions and children living in residential care because fostering was unavailable. [110,112,138]

That may produce useful information about individual children. But it also makes the question of evidential influence more important. A measure cited nationally to support expansion of fostering is now being used within a regional reform programme intended to reshape placement decisions and markets.

The issue is not whether BERRI should be used. It is whether one measure is acquiring influence across policy, assessment and implementation before the limits of what it can establish have been kept sufficiently visible.

Children do not experience fostering and residential care as separate policy programmes.

They experience one life.

Fostering capacity is not simply a recruitment number

Current fostering data make that separation more difficult.

During 2024–25, 4,430 mainstream fostering households joined the sector, but only 3,050 were genuinely new to fostering.

During the same period, 4,690 mainstream households deregistered. [103]

Recruitment is therefore only part of the problem.

The more important question is whether available foster homes can meet the needs of children requiring placements.

How many can care for teenagers?

Sibling groups?

Children with disabilities?

Children whose previous placements have broken down?

Children whose behaviour presents significant risk?

And where does that capacity sit?

Almost half of mainstream fostering households are now with independent fostering agencies. [103]

Those agencies therefore cannot be treated as peripheral to a government strategy dependent upon expanding fostering.

They are part of the infrastructure through which that strategy would have to operate.

They hold knowledge about recruitment, matching, specialist fostering, placement stability and breakdown, commissioning and the limits of what foster households can reasonably be expected to provide.

Local-authority fostering services hold another part of that knowledge.

Foster carers themselves hold another.

Capacity has to be capable of meeting the needs of the child who requires it.

That applies to fostering just as much as residential care.

Room Makers brings the distinction into particularly sharp focus. [112]

A bedroom is not a placement

Room Makers is part of the fostering expansion programme.

Public money is being used to renovate or extend the homes of experienced foster carers to create additional physical capacity.

For some children and foster families, that may be exactly the right investment.

It may allow brothers and sisters to remain together.

It may enable an experienced foster carer to offer a home to another child.

It may prevent a child moving away from people and places they know.

But it also exposes the weakness of treating physical capacity as though it were the same as caring capacity.

A bedroom becomes a placement only when the child, foster carers, children already living in the household and wider family are safely compatible.

The usual fostering limit already allows a foster household to care for the same number of foster children as a small three-place children’s home. Exemptions can allow more in particular circumstances.

Yet the two settings operate within very different regulatory structures.

A children's home is individually registered and inspected. It has a registered provider and manager, defined management responsibilities, staffing arrangements and independent scrutiny of the individual establishment.

A foster household is assessed, approved and supervised through its fostering service.

It is not individually registered and inspected as a care establishment.

The argument is not that fostering and residential care should be regulated identically.

They are different.

The question is what happens when policy deliberately expands the capacity of foster households and expects them to undertake care that might otherwise have been provided in staffed residential settings.

When does an enlarged foster household begin to operate as a form of group care?

What account is taken of the cumulative needs of children already living there?

What happens when additional support around the foster family begins to resemble a staff team?

At what point does the scale or organisation of the care require different safeguards?

There is also an evidential question.

Counting rooms created does not tell us whether suitable and sustainable placements have been created.

Do the placements last?

What happens to the children?

Does the capacity remain available?

Does the investment achieve what was intended?

If Room Makers forms part of the case for residential care being used for far fewer children, success cannot be measured simply by counting bedrooms.

It has to be measured by what happens to children.

Room Makers also represents another stage in the longer history of fostering.

Public money is being used to adapt and extend foster carers' homes in order to create additional placement capacity.

For some families and children that may be entirely appropriate.

But it makes the dual character of modern fostering particularly visible.

The home is simultaneously a private family space and part of publicly funded care infrastructure.

The additional room remains part of the household.

Its creation has been funded because the care system requires capacity.

Policy cannot rely on the romance of the family home while ignoring the infrastructure being built around it.

The historical trajectory is now difficult to miss.

Boarding out.

Paid fostering.

Specialist fostering.

Contract fostering.

Professionalised fostering.

Independent fostering agencies.

And now publicly funded expansion of private family homes in order to increase placement capacity.

None of these developments makes fostering less capable of providing meaningful family relationships.

But together they make it impossible to describe modern fostering simply as family life standing in opposition to an institutional residential sector.

The policy crosses the boundary between fostering and residential care. The published examination of it does not.

A smaller specialist sector creates another problem

The proposal for a smaller, more specialised children's homes sector has to be considered against this evidence.

It creates two risks.

The first concerns children who clearly need highly specialist provision.

What happens if no suitable place is available?

Specialist provision cannot necessarily operate permanently at full occupancy while retaining meaningful matching.

The more specialised the service, the more important spare capacity may become.

The second risk concerns children who could benefit from residential care but do not meet whatever threshold eventually defines specialist provision.

What happens to them?

A policy that reserves residential care increasingly for children with the greatest complexity does not remove the needs of children who would have benefited from residential care earlier.

It changes who can access it and when.

It concentrates greater complexity within the sector.

That changes the work.

It changes the skills required.

It changes the pressures on relationships.

It changes the risks.

And it may change the culture of the homes themselves.

Ofsted's evidence of repeated foster breakdown makes this difficult to dismiss.

If children repeatedly experience placements that cannot meet their needs before residential care becomes available, the system may itself contribute to the escalation that later justifies a specialist residential placement.

Children should not have to deteriorate until they meet the threshold for the provision that remains.

Can the policy be delivered?

The current evidence contains another apparent contradiction.

At 31 March 2026, Ofsted recorded 4,750 children's homes, including short-break-only homes, providing around 16,200 places. [109]

The number of homes had risen sharply.

Most were privately owned.

Yet local authorities continue to struggle to find suitable placements.

Provision remains geographically uneven.

More homes therefore does not necessarily mean sufficient suitable provision.

Government acknowledges the mismatch between what is available and what children need.

Government is investing in additional residential capacity while also saying residential care should be used for far fewer children.

The unresolved question is whether a smaller, more specialised sector can provide sufficient suitable choice for the children who need it.

The literature does not demonstrate that another reduction will solve the sufficiency problem.

It shows that the relationship needs investigating.

Who employs the workforce?

A workforce review cannot sensibly separate workforce development from the organisations that already employ that workforce.

The residential child care workforce is employed across public, private and voluntary organisations on different terms. Pay, pensions, occupational sick pay, contracted hours and other conditions vary between employers. Those differences affect recruitment and retention, but they also affect the cost of providing the service.

Those costs are not fixed. The relationship between public and private-sector pay changes over time. If private providers have to increase wages to attract and retain staff, their wage bills rise. If public-sector pay and employment costs rise faster, the cost of directly provided services increases. The relative cost of different types of provision can therefore change without anything about the needs of children having changed.

That matters when government is considering greater professionalisation.

Higher qualifications and greater professional status are likely to bring expectations of better pay, clearer career progression and protected training. As a new qualification becomes sought after by employers, it is also likely to increase competition for staff who already hold it.

We have already seen some of these tensions develop in fostering.

Fostering has become increasingly professionalised, regulated and fee-paid, while local authorities and independent fostering agencies compete to recruit and retain carers. Fees, support, respite and other arrangements can differ between fostering services. Yet employment status has not followed professionalisation in the same way.

In April 2026, Josh MacAlister stated that the government did not believe fostering should be considered a form of employment. He described foster care as a family-based vocation and argued that foster homes should feel like family homes rather than workplaces. [196]

That is the intention. It does not mean that every child experiences foster care in that way.

Nor does describing fostering as a vocation remove the recruitment and retention problem. Fostering services are competing for a limited pool of people willing and able to foster, while more households are leaving fostering and only a small proportion of initial enquiries ultimately result in approval. The language of vocation does not remove that reality.

The importance of employment status therefore extends beyond language. Foster carers can undertake highly regulated, demanding and remunerated work without acquiring the employment rights ordinarily associated with a job. At the same time, fostering services compete for them through fees, support, respite and other arrangements.

That competition has also contributed to changes in the nature of fostering. Earlier fostering was not organised around a market in which different fostering services competed to recruit carers through different packages of fees and support. The development of specialist and contract fostering, followed by independent fostering agencies and the growth of fee-paid fostering, progressively changed that relationship.

Fostering remained family based, but an increasingly professional, commissioned and competitive infrastructure developed around it.

Fostering therefore provides a useful warning about professionalisation. A role can become more skilled, regulated and economically significant without questions of status, remuneration and conditions being resolved alongside it.

The residential workforce is different because its members are employees. But the underlying lesson remains relevant.

Professionalisation changes expectations.

Qualifications acquire value.

Employers compete for people who hold them.

And that has consequences for pay, recruitment, retention and cost.

The question is therefore not simply what qualification the workforce should have.

It is also who employs that workforce, on what terms, and whether those employers can sustain the workforce government says it wants.

If provision disappears, the loss is not simply a bed.

Staff disperse.

Experience disperses.

Relationships end.

Organisational knowledge disappears.

Recreating those things later is neither quick nor simple.

Who will run the homes?

The terms of reference say the conclusions of the workforce review will directly inform new DfE-funded children's homes.

But DfE-funded does not necessarily mean publicly run.

Somerset provides a useful example.

Homes and Horizons was established as a partnership involving Somerset Council, Homes2Inspire and Somerset NHS Foundation Trust, combining residential homes, fostering and therapeutic education for children with higher levels of need.

Public investment was central.

Properties were purchased.

Capital funding was committed.

But the council did not itself operate the residential homes.

Homes2Inspire did.

Operational problems subsequently emerged and Shaw Trust announced its intention to end its involvement before the original term of the partnership had expired.

The properties did not disappear.

But the service depended on more than buildings.

It depended on a registered provider.

Managers.

A workforce.

Leadership.

Relationships with children.

And an organisation willing and able to continue carrying responsibility.

A children's home is not a building.

Government is again investing public money in residential capacity. That could rebuild public capacity, but it does not necessarily do so.

Publicly funded is not the same as publicly run. Publicly owned is not the same as publicly operated.

If public investment is to create lasting capacity, we need to know who will own the homes, who will operate them, who will employ the workforce, who will carry the operational risk and where the knowledge remains if the provider withdraws.

How did illegal children's homes become part of the system?

It is illegal to operate a children's home that should be registered with Ofsted without registration.

That principle is clear.

What happened in practice is much less comfortable.

Unregistered children's homes were not an entirely new kind of problem. They were a later echo of the unresolved boundary between care and support. The earlier history of semi-independent provision had already shown what could happen when children were placed in arrangements defined by the regulatory category of the service rather than by what the child actually needed.

There was an important difference. Supported accommodation could be lawful and appropriate for the right older child. But once a provider was in fact providing care as well as accommodation, the question was no longer simply whether the placement was suitable. If the establishment met the definition of a children's home and was not registered, its operation was unlawful.

Yet the system failure could begin before that point. A local authority could know that a child needed care but be unable to find a registered home able to provide it. An arrangement described as support might then be purchased because it was available. The provider might provide increasing levels of care because the child plainly required them. By the time the regulatory boundary had been crossed, the earlier failure was already visible: the child needed lawful care and the system could not provide it.

The number of children reported to Ofsted as having been placed in unregistered homes at some point during the year increased from 147 in 2020–21 to 982 in 2023–24.

By September 2024, the Children's Commissioner found 775 children living in unregistered accommodation.

The average stay was more than six months. [105]

By 1 September 2025, 669 children were still living in illegal homes.

Eighty-nine had remained in the same illegal placement for more than a year.

The average weekly cost was around £10,500.

Local authorities were estimated to have spent £353 million on these placements during the preceding twelve months. [106,107]

Some of the children were subject to court-authorised restrictions on their liberty.

Some were living in houses or flats.

Others were accommodated in holiday properties, activity centres, holiday camps or caravans.

These were not hidden placements existing entirely outside the public system.

Public authorities were purchasing them.

Local authorities knew they were placing children in unregistered provision.

Courts knew about some of the arrangements when asked to authorise deprivation of liberty.

Government knew the numbers were increasing.

Ofsted knew unregistered provision was growing.

And yet the practice continued.

This is important because language can conceal what has happened.

An emergency placement might initially appear exceptional.

One placement becomes another.

A child remains longer than anticipated.

Another child cannot be found a registered home.

Local authorities facing the same shortage make the same decision.

A response that is unlawful but presented as unavoidable can gradually become embedded.

Illegal provision was unlawful, but its repeated use became normalised within a lawful system.

That requires more than a discussion about unlawful providers.

It requires examination of how a statutory care system reached a point where hundreds of children could live for months in provision that legally should not have existed.

The earlier evidence from Ofsted helps explain why criminal enforcement alone did not stop the practice. But it does not explain how a statutory care system reached the point at which illegal provision became part of its response to children for whom no suitable lawful placement could be found.

An unlawful provider was still operating unlawfully.

But the child still had to live somewhere.

The local authority still had responsibilities towards that child.

Courts still had to decide whether restrictions on the child's liberty could lawfully be authorised.

Ofsted still had responsibilities for registration and enforcement.

And government knew the problem was growing.

Each part of the system could explain the responsibility it held and the limits of its authority. None of those explanations gave the child a suitable lawful home.

Registration itself also belongs within the history.

Ofsted has had to manage large volumes of applications while determining whether proposed providers, managers and premises meet regulatory requirements.

Priority applications can be accelerated where children are already living unlawfully under deprivation of liberty arrangements or where exceptional need can be demonstrated.

But registration takes time.

That does not make operating without registration lawful.

Nor does it justify bypassing safeguards.

It demonstrates why the problem cannot be reduced to rogue providers alone.

There is a wider history of sufficiency, commissioning, registration and accountability.

In July 2026, Ofsted changed its approach again.

It acknowledged that although there were more children's homes than ever before, volume alone had not produced sufficiency.

Homes were often too small, in the wrong places or unable to meet the needs of the children requiring residential care.

Ofsted revised its approach to prioritising registration applications so that identified demand, geography and specialist need could play a greater role. [119,120]

That response matters.

It recognises something this literature review has repeatedly found.

More provision is not necessarily the same as the right provision.

But it raises another historical question.

Why did it take the growth of illegal provision for that distinction to become so explicit?

For years, individual providers applied to register homes.

Local authorities purchased placements.

Ofsted registered and inspected provision.

Government monitored the system.

Markets developed.

Yet the cumulative result was thousands of registered homes alongside hundreds of children living in unlawful provision because a suitable registered home could not be found.

That is not simply provider failure. It is system failure.

An unlawful provider remains responsible for operating unlawfully. But that cannot explain why the lawful system became repeatedly dependent upon unlawful provision.

Ofsted is part of that system.

Not solely responsible for it.

But not outside it either.

The same is true of local authorities.

Government.

Commissioners.

Providers.

Courts.

The history of illegal children's homes demonstrates what happens when responsibility becomes divided across organisations while the child remains in the middle.

Everybody can explain the limits of their own authority.

The child still needs somewhere to live that night.

That brings us back to one of the central questions in this review.

What did the system know, when did it know it, and what changed as a result?

What did the journey cost?

Residential care is expensive.

Some placements are extraordinarily expensive.

That deserves scrutiny.

But the weekly cost of the final placement tells us little about what happened before the child reached it.

A child may experience several foster placements and, in exceptional cases, many more.

Each may cost less per week than residential care.

But if placements repeatedly break down, the care journey also brings the cost of placement searches, social-work time, emergency arrangements, assessments, additional support, school changes and unavoidable travel to placements far from home.

It also costs something much harder to price.

Lost relationships.

If the child eventually enters intensive residential provision, comparing the weekly price of that home with the price of an earlier foster placement tells only part of the story.

The more meaningful question is:

What has the child's whole care journey cost, financially and humanly, and what did that expenditure achieve?

Otherwise the system can make a series of individually cheaper decisions and still produce a more expensive and damaging result.

The cost of illegal provision makes that argument even harder to avoid.

If hundreds of children can be placed in unlawful provision costing around £10,500 a week because appropriate lawful provision was unavailable, the financial question cannot begin when the crisis placement starts.

It has to begin much earlier.

What provision disappeared?

What placement broke down?

What alternative was unavailable?

What support might have prevented the breakdown?

What investment was not made because spare capacity was regarded as inefficient?

And how much was eventually spent when the system had run out of lawful options?

The cost of starting again

The history of secure care strengthens the argument about institutional memory.

It also takes us back to the earlier history of youth justice and the unresolved relationship between care and control.

In the mid-1980s, secure provision was still extensive. In 1985 there were 44 approved local authority secure facilities in England, falling to 42 by 1987 and 34 by 1990. The historical categories are not directly equivalent to today's registered secure children's homes, but they show the scale of secure homes that once existed. The contraction of that provision matters when considering what came next. [212]

Secure Training Centres emerged from the increasingly punitive political response to youth crime during the 1990s.

They were conceived under John Major's Conservative government and provided for by the Criminal Justice and Public Order Act 1994. The contract for the first centre was signed in March 1997, shortly before the general election.

Labour inherited the model.

The first Secure Training Centre opened at Medway in April 1998. Labour chose to continue with the contract and subsequently retained Secure Training Centres within its wider reform of youth justice, during a period in which Tony Blair's promise to be "tough on crime, tough on the causes of crime" had become central to Labour's approach to law and order.

Secure Training Centres were also part of a wider move towards contracting public services to private providers.

An early example of lost institutional memory followed.

When Secure Training Centres began in 1998, the Home Office committed to reviewing the Physical Control in Care restraint system after one year.

That review did not happen.

The Youth Justice Board later acknowledged that, when responsibility for secure facilities transferred from the Home Office, the commitment had been "lost sight of."

A review did not begin until 2004.

Before it was properly under way, fifteen-year-old Gareth Myatt died at Rainsbrook Secure Training Centre on 19 April 2004 while being restrained.

Less than four months later, fourteen-year-old Adam Rickwood took his own life at Hassockfield Secure Training Centre, hours after being subjected to a pain-inducing restraint technique.

Two boys had died.

Restraint was central to what happened to both of them.

Their deaths led to inquiries, reviews and changes to restraint practice.

The restraint used on Gareth Myatt was discontinued. Physical Control in Care was medically reviewed and training was revised, with greater emphasis placed on restraint as a last resort, behaviour management and de-escalation. A different national system of restraint was later introduced.

But the Secure Training Centre model continued.

That distinction matters.

The problems were not first discovered when Ofsted became responsible for inspecting Secure Training Centres in 2007.

Before then, inspection had been led first by the Social Services Inspectorate and later by the Commission for Social Care Inspection. Earlier inspection evidence had already identified problems with management, staffing, practice and the care of children.

Ofsted assumed responsibility on 1 April 2007.

The change of inspectorate did not mark the beginning of the problems.

Nor did the deaths of two boys bring the model to an end.

Hassockfield remained in use until March 2015, more than ten years after Adam Rickwood died there. Its closure reflected falling demand for custodial places rather than a decision to abandon the Secure Training Centre model.

By then another reform was already beginning.

Charlie Taylor, a former headteacher whose professional background was in education and behaviour, was commissioned in 2015 to review the youth justice system.

But this was not his first government commission, nor was Michael Gove new to his work.

Gove had appointed Taylor as the Department for Education's Expert Adviser on Behaviour in 2011 and subsequently asked him to review alternative provision. Taylor later became chief executive of the Teaching Agency and then the National College for Teaching and Leadership.

In September 2015, with Gove now Secretary of State for Justice, Taylor was asked to review youth justice.

His 2016 review proposed secure schools intended to put education and rehabilitation at the centre of custody within a more therapeutic environment.

The connection with the wider education reform programme was explicit in the model Taylor proposed.

Secure schools were to be created within schools legislation and, in England, commissioned in a similar way to alternative provision free schools. Taylor proposed considerable autonomy for the headteacher to recruit staff, commission services and determine the programme of activity within the school.

The review therefore brought into youth justice a method of reform already familiar in education: new organisational structures, greater institutional autonomy and considerable authority placed in individual leaders.

That does not invalidate Taylor's conclusions. But it does make the choice of reviewer relevant.

The question is not simply whether Taylor had relevant knowledge of children with behavioural difficulties. He plainly did.

It is why a review capable of fundamentally reshaping secure care was led principally through an education and behaviour lens, and how much knowledge from secure residential child care was represented alongside it.

In 2017 Taylor was appointed Chair of the Youth Justice Board without an open competition. The exceptional appointment was publicly recorded. Ministers said he was uniquely placed to lead the Youth Justice Board through the changes and drive forward the reform agenda.

The pattern is familiar.

Expert adviser.

Reviewer.

Architect of reform.

Then Chair of the body responsible for helping to take that reform forward.

That does not establish that the outcome of Taylor's review was predetermined.

But it does raise the same question that arises elsewhere in this review.

Who government chooses to conduct a review helps determine the knowledge through which the problem is understood and what the review is at liberty to discover.

Government accepted the recommendation for secure schools.

But Secure Training Centres continued while the new model was being developed.

Medway was operated by G4S until 2016, when the state took it back into direct management following serious safeguarding concerns. It remained open until March 2020.

Rainsbrook was operated from 2016 by MTCnovo, later MTC UK, whose parent company is the US-based Management & Training Corporation.

MTC had extensive experience in correctional and justice services. Its US parent company began operating correctional facilities in the 1980s.

That background is relevant.

It raises a legitimate question about what kind of knowledge government valued when deciding who should care for children in custody, and how much knowledge rooted in residential child care informed those decisions.

Children were removed from Rainsbrook in June 2021 following continuing concerns about safety and performance. The government terminated MTC's contract later that year.

Oakhill remained.

From 2017, inspectors repeatedly judged Secure Training Centres as either requires improvement or inadequate. The National Audit Office found that they received one of those two judgements in every year from 2017. [79]

By June 2026, twenty-eight years after the first Secure Training Centre opened and twenty-two years after the deaths of Gareth Myatt and Adam Rickwood, Oakhill was still operating.

In June 2026, its most recent full inspection judged children's overall experiences and progress inadequate and how well children were helped and protected inadequate. Inspectors continued to identify serious safeguarding concerns, violence and use of force. [208]

The question is why the Secure Training Centre model itself, associated with persistent concerns about the care and treatment of children, was allowed to continue for so long.

The secure-school model was intended to provide something different.

Its design returned to characteristics already familiar within secure children's homes, including a greater emphasis on education, health, individual need, relationships and a more therapeutic environment.

But scale matters too.

Oasis Restore was designed to accommodate up to 49 children.

At its designed capacity, the first secure school remained much closer in scale to a Secure Training Centre than to any current secure children's home.

Government therefore returned to characteristics associated with smaller, relationship-based secure children's homes without returning to their scale.

Secure children's homes already existed. In the early 1990s, I managed a children's resource centre with management responsibility for its secure children's home and was also part of the design team for a new purpose-built secure unit.

Secure Training Centres had been created as something different.

Serious problems followed.

Almost two decades after the first Secure Training Centre opened, another model was proposed.

What had been learned, and why had it taken another reform to revisit knowledge already present elsewhere in the system?

Oasis Restore accepted its first placement in August 2024. [102]

Its development has itself raised further questions.

Serious problems with the security of the building led to placements being paused and Oasis Restore temporarily closing while remedial work was undertaken.

This is where earlier secure-care experience matters.

Operational knowledge can be built into the design of a secure unit when those who understand how it will actually function are involved in creating it.

The problems at Oasis Restore therefore raise another question about institutional memory:

What secure-care design expertise was carried forward when the new model was created?

On 28 May 2026, Ofsted visited Oasis Restore with a specialist architect. Inspectors concluded that the principal security and safety concerns identified the previous year had been addressed, although further work was still required in parts of the building.

A further monitoring visit took place on 4 June 2026. Ofsted then lifted the condition requiring three months' notice before children could be admitted and varied the registration to allow Oasis Restore to care for up to 24 children. [102]

But this was not a return to the secure school originally designed for 49 children.

The reopening was staged. A small number of children were to be admitted initially, with numbers increasing gradually. Children arriving at the school were not to have access to other children until their risks and vulnerabilities had been understood. A temporary admissions area still required further work and approval by the specialist architect. One education building and two residential buildings also remained unavailable and would require a further variation of registration before children could use them.

The public cost matters too.

The original estimate for converting the former Medway Secure Training Centre into a secure school was £4.9 million. By 2022, that estimate had increased to £36.5 million, largely because significant design revisions were required following due diligence. The National Audit Office also recorded that the school was expected to provide 49 places. [79]

Later evidence submitted to Parliament put the refurbishment cost at almost £40 million. [209]

That raises another question about design, institutional memory and public money.

A secure school designed for 49 children required substantial redesign before opening, later closed because of serious security problems, and in June 2026 reopened on a staged basis with registration for up to 24 children while further building work remained outstanding.

Before this model is reproduced elsewhere, government should be able to say what the first secure school has cost in full, why fundamental security problems were not identified before it opened, what the closure and remedial work added to that cost, and what has been learned from the experience.

It remains too early to judge what the secure-school model will ultimately achieve.

But the history raises a wider question:

When government creates a new structure, what knowledge from the structure it replaces, or from services that exist alongside it, is carried forward?

The restraint question does not end with secure care.

The wider framework for physical intervention and restraint in children's homes also deserves examination.

The law sets limits on when restraint can be used and requires it to be necessary and proportionate.

But there is no single national model of physical intervention and no standard set of techniques used across children's homes.

Different organisations use different training systems, models and techniques. Even the language used to describe individual holds can mean different things in different systems.

The question is therefore not simply whether restraint is permitted. It is what restraint means in practice, which techniques are being used, how their safety is assessed and whether the system is capable of seeing patterns across different homes.

That question belongs within the wider argument about institutional memory.

The forgotten review of restraint in Secure Training Centres shows how knowledge can be lost when responsibility moves.

The wider use of different restraint systems across children's homes raises a related question about how learning travels between organisations and across the sector.

Without systematic examination, harmful practice can be identified in one place without the learning travelling across the system.

Residential knowledge can be lost.

Overlooked.

And later returned to under another name.

The history of secure care therefore forms part of the larger history of children's social care.

It shows welfare and justice being brought together.

Separated.

Reorganised.

Contracted out.

And then partly reconnected through another new model.

It also shows what can happen when structural reform proceeds without institutional memory.

The missing link: secure care

There were 14 secure children's homes across England and Wales in March 2026. [108]

Twelve were run by local authorities and two by voluntary organisations.

None was privately operated.

Their numbers are small.

The needs of children using them can be substantial.

Some children have experienced repeated placement breakdown.

Some have mental-health or disability needs.

Some have offended.

Some require severe restrictions on their liberty for their own safety or the safety of others.

The care-and-control debate is still with us.

That alone places secure care within the questions this workforce review is being asked to consider. The connection is also recognised elsewhere in the reform programme. The Independent Review proposed Regional Care Cooperatives covering fostering, residential and secure care.

Yet no secure children's home manager or representative of the specialist secure-care network is visibly identified among the five named people leading the current workforce review.

That is not a criticism of those who are there.

It is a question about what knowledge is absent.

The purpose of residential care

The terms of reference ask about "the purpose of residential care."

But the literature does not describe one purpose.

Residential care can provide long-term care, assessment, preparation for adulthood, secure care, disability support, education alongside care, therapeutic intervention, crisis provision, support towards reunification or simply a stable home during adolescence.

The CELCIS rapid evidence review of the function, quality and outcomes of residential care illustrates the difficulty. It found relatively few studies that explicitly examined purpose. Where purpose was addressed, residential care was generally understood as part of a continuum of support and protection for children unable to live with their parents or families.

That is a much broader purpose than specialist treatment for a small group of children with highly complex needs.

It is also closer to the historical reality described throughout this review.

The review team itself acknowledges that children's homes are not one intervention.

The language of intervention nevertheless matters. Residential care can be an intervention. It can also be a child's home, sometimes for a considerable period.

If residential care is framed principally as an intervention before its purpose has been examined, the range of possible answers is narrowed before the evidence has done its work.

That should change the question.

Rather than asking:

What is the purpose of residential care?

ask:

What does this child need residential care to do?

The first begins with the service category.

The second begins with the child.

The therapeutic legacy

The proposal for a more specialised residential sector also raises questions about what specialised means.

Therapeutic residential care is not a recent discovery.

Winnicott and Britton were writing about the therapeutic possibilities of residential management in the 1940s.

Bowlby was drawing attention to separation, relationships and continuity.

Dockar-Drysdale and others developed therapeutic residential traditions.

Attachment theory subsequently became highly influential across fostering, adoption and residential practice.

Later developments drew upon developmental psychology, neuroscience and an expanding understanding of trauma.

What is now described as trauma-informed care belongs within that longer intellectual history.

The language is newer.

Many of the underlying concerns are not.

Safety.

Reliable relationships.

Continuity.

The meaning of behaviour.

Emotional regulation.

Understanding what has happened to a child rather than treating behaviour in isolation.

The effect of repeated loss.

The importance of adults remaining available through difficulty.

These concerns can be traced through different theoretical traditions across several generations.

That does not mean trauma-informed practice simply repeats Bowlby or Winnicott.

Knowledge has developed.

The evidence base has expanded.

Our understanding of neurological and developmental processes has evolved.

But it does mean that trauma-informed care did not arrive in a historical vacuum.

There is a journey through this literature.

From wartime separation and residential management.

Through Bowlby and attachment.

Through therapeutic communities and psychodynamic traditions.

Through attachment-based practice.

Into developmental trauma, neuroscience and contemporary trauma-informed approaches.

It is not a single straight line.

The traditions overlap.

Sometimes they disagree.

Sometimes new terminology gives greater precision to something practitioners had already observed.

Sometimes old ideas reappear in new language.

And sometimes complex theories are simplified as they travel.

The English social pedagogy pilot provides a useful test of this problem. Social pedagogy was presented as an approach being introduced into an English workforce that was said to lack its relational and developmental orientation.

The evaluation found something more complicated. Many residential workers regarded substantial parts of the approach as already familiar within their existing practice. The difficulties lay not simply in introducing a philosophy, but in implementation, organisational culture, leadership and context within a heavily regulated system.

That is not an argument against social pedagogy.

It is an argument against treating an imported professional model as though it lands on an empty page.

Berridge has similarly warned against simplistic policy transfer between countries, and Narey cautioned against assuming that international residential systems can simply be transplanted into England.

The harder question is not whether social pedagogy or therapeutic care is good or bad.

It is what elements work, for which children, in which settings, delivered by whom, with what training, support, leadership and organisational conditions.

That is why no single model should become synonymous with good residential child care.

Current literature on trauma-informed care also calls for caution.

The term covers a wide range of approaches rather than one agreed model. Much of what is described as trauma-informed overlaps with longstanding elements of good child-care practice, including reliable relationships, understanding behaviour in context, emotional safety and reflective practice.

Enthusiasm is not the same as evidence of outcome.

That does not make trauma-informed practice unimportant.

It means it should remain open to evaluation and challenge.

There is also a difference between understanding trauma and allowing trauma to become the explanation for the child. Young people contributing to the evidence described experiences in which trauma was used to explain who they were or why they behaved as they did. The same evidence supported trauma awareness while warning against its use to stigmatise. [193]

For one child, specialist psychological intervention may be essential.

Another may need a highly structured therapeutic environment.

Another may need a stable home, reliable adults and relationships that survive difficulty.

Daily life matters.

Meals matter.

School mornings matter.

Bedtime matters.

Arguments and repair matter.

Adults remaining present when things are difficult matters.

NICE found similar things in its review of children's wellbeing. Outings, opportunities to develop interests, shared activities and informal time with carers and professionals were identified as supporting wellbeing. The committee described these as reflecting healthy and caring parenting practices. [193]

Across generations, residential child care literature has repeatedly identified the importance of relationships, continuity, safety, understanding behaviour and the emotional meaning of everyday life.

That should make us cautious when long-established ideas are presented as new discoveries.

Therapeutic should describe what care does for the child, not simply the kitemark an organisation carries.

Therapeutic and psychological knowledge have an important place in residential child care.

Children should have access to psychological, psychiatric, therapeutic and health expertise when they need it.

But residential child care is not clinical treatment.

The boundary between social care and treatment matters.

Specialist knowledge should add to residential child-care knowledge, not replace it or be treated as though it lands on an empty page.

Residential child care already has a history, a body of knowledge and generations of practice concerned with relationships, separation, attachment, behaviour, care and control, everyday living and the developmental needs of children.

There is a useful parallel with adult social care.

For years, policy has recognised that people should not remain in hospital simply because appropriate social care is unavailable. A hospital can provide treatment, but it is not a substitute for a home or for the social care that enables somebody to live outside it.

The same distinction matters in children's residential care, although the risk may run in the opposite direction.

A child may need treatment without needing to live in a treatment service.

A children's home is first a place where a child lives.

NICE makes a similar distinction. Faced with delays in CAMHS and concerns that some mental-health services were not designed around the needs of children in care, its committee considered therapeutic and specialist support around the child's care network. It was explicit that this should not replace CAMHS. It also warned that introducing a child to one therapist only for that person to change when another service took over could itself lead to disengagement. [193]

The answer to a child needing specialist help is therefore not necessarily to turn the place where they live into the specialist service.

That does not make what happens there non-therapeutic. Relationships, safety, stability, boundaries, ordinary routines, belonging and being cared for can themselves have therapeutic value.

There is a further question about who defines need. Social work academic Stan Houston drew attention to the fact that needs are not interpreted in a neutral space. The professional framework through which a problem is understood can itself influence the need that is identified and therefore the solution that follows. [194]

Who defines the child's need, and through which professional lens?

The question is whether specialist knowledge is being brought alongside residential child care, or whether residential child care itself is gradually being redefined through a treatment model.

That question becomes more important if fostering remains the principal alternative.

If residential care is increasingly defined as specialist treatment while fostering is promoted as the preferred form of care, the choice risks becoming:

family care or treatment.

Some children will fit neither.

They may not be able to live successfully in foster care, but neither do they necessarily need to live in a clinical or treatment setting.

They may need residential child care.

A place to live with adults who know them, care for them, provide boundaries and continuity, share everyday life with them and bring in specialist support when it is needed.

If that middle ground is lost, children may be pushed through repeated foster placements before reaching residential care or placed in provision that is more specialist than they need.

That does not increase choice. It narrows it.

The issue is therefore not whether residential child care should be therapeutic.

It should be capable of being therapeutic.

The purpose of professional development should be to expose practitioners to evidence, history, competing theories and different approaches and strengthen their capacity to think.

The model should follow the child, not the child the model.

Is residential child care being professionalised as social care, or is it gradually being remodelled as a treatment service?

What makes a profession?

The argument for strengthening the professional status of residential child care is well established.

The 1998 Health Committee discussed workforce status, qualifications, recruitment and training.

IICSA later recommended professional registration for people working in care roles in children's homes. It said registration should be through an independent body responsible for standards of training, conduct and continuing professional development, with fitness-to-practise powers. It recognised that this might need to be phased in and said children's home managers should be the first priority. [71]

The Department for Education commissioned its own literature review and call for evidence.

The literature review found insufficient evidence that professional registration alone would improve child protection. [73]

Government therefore kept professional registration under review while continuing to consider workforce development more broadly. [134]

The Independent Review subsequently recommended professional registration of the residential child care workforce, beginning with managers. [76]

The present workforce review now returns again to knowledge, skills, qualifications, continuing professional development, careers and accountability.

The Children's Homes (England) Regulations 2015, although amended, remain the main regulatory framework for children's homes today. They already set requirements around staffing, management, qualifications and the Quality Standards. Any review of the workforce therefore begins within a framework that has been in place for more than a decade. [60]

If government is reconsidering what the residential workforce should know, how it should be trained and how it should be professionalised, it should also ask whether the regulations governing children's homes still reflect what residential child care is expected to do now, and whether they will remain fit for the role government proposes for it.

The present review is therefore not starting with an undefined workforce. It is examining a workforce already shaped by regulation, qualifications, inspection and professional expectations.

The professionalisation of residential child care has a history too.

Residential child care once had a recognised professional identity as residential social work. In 1998, the House of Commons Health Committee was still writing explicitly about residential social workers and field social workers.

But the two had not developed with equal status. The Committee found that field social work offered greater status and better rewards, and that residential workers who gained professional qualifications often moved into field work. It also identified a two-tier system in which field social workers normally retained responsibility for the child's care plan even when the child was living in residential care. The people living alongside the child could therefore know that child through everyday life while holding less formal authority over the decisions that shaped it.

The Committee called for the responsibilities of field and residential social workers to be rebalanced.

Instead, the distinction subsequently became sharper. The title social worker became legally protected in England in 2005. Protection of title did not create the hierarchy between field and residential work, it crystallised it. Contemporary local-authority records show residential social worker posts being renamed because staff who were not registered social workers could no longer use the title. One part of the workforce acquired a protected professional identity while residential social work progressively lost the identity through which it had previously described itself.

That history matters now. Field social work and residential child care share responsibility for children, but they are different roles, with different histories and different relationships with children. A workforce review considering qualifications, registration, professional development and career pathways should therefore ask what happened to residential social work, why field social work acquired greater professional authority, and whether current proposals are building a profession of residential child care in its own right or reproducing an older hierarchy.

There is an important distinction between being registered to manage a particular children's home and being registered as a professional.

Ofsted decides whether a manager is fit to manage a particular home. Professional registration is different. It follows the person, not the home.

Social workers have that professional status independently of the service in which they work.

If residential child care is to be professionalised, registered managers need comparable professional standing.

That does not mean residential child care should become social work. It means recognising residential child care as a profession in its own right, with its own knowledge, standards, continuing development and accountability.

A higher qualification alone will not create that professional status.

The same evidential test should apply to Level 6. The procurement justification identifies the Graduate Diploma in Residential Work (Children's) as part of the reason for selecting Catch22. That does not establish that a Level 6 qualification is wrong. It means its additional value must be demonstrated.

What knowledge and skill would Level 6 add?

What evidence shows that it would improve children's experiences and outcomes?

Would it apply to all residential workers or particular roles?

What would happen to experienced practitioners without graduate-level qualifications?

What would it cost?

Would it strengthen recruitment and retention or make them more difficult?

And would the same investment achieve more through pay, staffing, supervision, leadership and continuing professional development?

A qualification cannot compensate for poor leadership, inadequate staffing, weak supervision, excessive turnover or an organisation that does not listen when staff raise concerns.

NICE's evidence gives the organisational argument another dimension. Children and young people reacted strongly when social workers with whom they had built positive relationships changed. The review identified workload, burnout and career movement among the reasons for turnover, and recorded concern that performance indicators and administration could take priority over direct time with children. NICE consequently recommended attention to professional retention and to the impact of workforce turnover on children. [193]

Professionalisation therefore also depends upon whether organisations make sustained relationships possible.

My own route also informs why I ask this question. I qualified as a social worker thirteen years after entering children's social care, after experience in residential care and fostering. That does not tell us what qualification level is right now. It does make me resist any assumption that professional knowledge begins with the award of a qualification.

Professionalisation is not achieved simply by increasing the academic level of a qualification.

Professionalism involves more than the level of a qualification.

It involves knowledge.

Ethics.

Responsibility.

Judgement.

Supervision.

Accountability.

Continuing learning.

The ability to question accepted practice.

And sufficient professional status for that judgement to be heard.

It also requires history.

A profession needs to know what has already been tried, what was learned, what failed and what should not have to be discovered again.

Institutional memory is evidence

Children's social care has been repeatedly restructured.

Governments change.

Ministers change.

Political ideology changes.

Regulators change.

Inspection frameworks change.

But public institutions remain responsible for policy, evidence and learning across those changes.

So where does the memory sit?

The history examined here repeatedly raises the same problem. Specialist Children's Departments were created and then dismantled. Aftercare existed in 1948 yet leaving care repeatedly re-emerged as a policy problem. Winnicott, Britton and Bowlby placed relationships, separation and the therapeutic potential of everyday care at the centre of child-care thinking generations before contemporary language rediscovered them. Family support and intermediate treatment predated later early-help reforms. Specialist fostering for adolescents has been developing for around half a century.

The same question applies to more recent reform.

Parliament concluded in 1998 that residential capacity had been reduced too far. Narey warned in 2016 against further reducing reliance on children's homes. Ofsted has accumulated almost two decades of evidence from registering, inspecting and regulating children's homes and independent fostering agencies. Parliament warned that specialist social-care knowledge had been lost when regulation moved into Ofsted and later raised concerns again about the visibility of children's social care within its leadership.

The growth of unregistered homes, the regulation of supported accommodation, the social pedagogy pilot, the history of Secure Training Centres and the early evaluation of Regional Care Cooperatives all add to the same question:

What was learned, where was that learning held, and was it carried into the next reform?

These are not arguments against change.

They are arguments against repeatedly treating established questions as though they have never been asked before.

Institutional memory is not resistance to change. It is evidence.

What can history tell us?

History tells us what has been tried before and what happened afterwards.

It tells us what worked, what did not, what was lost and what had to be rebuilt.

That matters in children's social care because changing the structure has not always changed the need.

Residential care was reduced, but some children still needed residential care.

Fostering expanded, but it could not meet every child's needs.

Specialist Children's Departments were dismantled, but the need for specialist child-care knowledge did not disappear.

Youth justice was brought closer to child welfare and later separated from it again.

New boundaries were created around secure care and supported accommodation, but the children did not change because the boundary moved.

Permanence planning taught us that finding a placement is not the same as an enduring relationship.

Safeguarding taught us the importance of protecting children from adults who may harm them. It also showed what can happen when fear changes the relationships children have with the adults who care for them.

The therapeutic history tells us that questions about separation, attachment, relationships and the importance of everyday care were being asked long before the language we use today.

Reviews and inquiries have also left warnings.

Some were acted upon.

Some were not.

Some of the same problems returned.

History tells us what we already knew, what we tried, what happened and what we failed to learn from it.

That is why history matters to what happens next.

It is not simply background.

It is evidence against which the next set of assumptions should be tested.

What can evaluation tell us?

Some reforms that followed the Independent Review have evaluation arrangements.

But the chronology matters.

The first phase of the independent evaluation of the Regional Care Cooperative pathfinders was published in November 2025. It examined early implementation in Greater Manchester and the South East. It was not an impact evaluation of an established model. [93,97]

The evaluation identified promising early evidence around collaboration, shared purpose and more proactive planning. It also identified significant uncertainties and risks.

Timescales were challenging.

Capacity was limited.

Collecting and standardising data remained difficult.

Engaging partners and providers took time.

The additional burden of transformation was itself a risk.

The evaluation recorded concerns about market disruption and recognised that attempts to stimulate or regulate the market could produce unintended consequences, including reduced access to placements. It also made clear that it was too early to assess some central assumptions within the theory of change. Outcomes for children, families, the workforce and the wider system were unlikely to be visible quickly, and longer-term policy effects might take several years.

The evaluators concluded that time would tell whether the assumptions underlying the model held true and whether unintended outcomes or new risks emerged.

That does not say Regional Care Cooperatives will fail.

It says the evidence necessary to determine whether they work was not yet available.

Government nevertheless moved beyond the two pathfinders. In February 2026 it announced an accelerated phased rollout. An expression of interest followed in March. On 8 July, five additional Regional Care Cooperatives were confirmed in London, the North East, the East Midlands, the West Midlands and Cheshire and Merseyside. [115,116]

Together with Greater Manchester and the South East, seven Regional Care Cooperatives now cover more than 100 local authorities.

That is no longer simply a test of two pathfinders. It is substantial implementation of the model before the full evaluation of the original pathfinders is complete.

Government does not have to wait indefinitely for every evaluation before acting.

Policy is often made using incomplete evidence.

But the existence of an evaluation should not be confused with independent validation of the model being evaluated.

The reform is being expanded while evidence capable of establishing its longer-term effects is still being produced.

That strengthens the distinction between evaluating implementation and testing the premise.

An implementation evaluation can ask whether Regional Care Cooperatives have been established successfully, whether local authorities collaborate, whether data systems improve, whether commissioning becomes more coordinated and, eventually, whether outcomes for children improve.

It can also examine what happens to local knowledge, provider diversity, placement choice and the shape of the market as regional purchasing power increases.

Those are necessary questions.

But some of the consequences will only become visible once the model is operating at scale.

Commissioning is central to those questions. It does not simply purchase what the market happens to provide. The way services are commissioned influences what provision develops, what survives and what providers have to become in order to continue receiving placements.

Regional Care Cooperatives are intended to strengthen local authorities' purchasing power by bringing commissioning together across much larger areas. That may bring advantages. Better information about demand may support planning. Authorities may be less likely to compete for the same placements. Greater purchasing power may help challenge excessive prices.

But greater purchasing power is still power.

Providers respond not only to what Ofsted expects but to what commissioners are prepared to purchase. Frameworks, contracts, specifications, pricing arrangements and purchasing systems can reshape the provider landscape.

Smaller providers may be particularly exposed. They are less likely to have the procurement, compliance and financial infrastructure of large organisations, may be less able to carry vacancies or absorb downward pressure on fees, and may find complex tenders or block purchasing harder to accommodate.

The consequences of exclusion may also become greater. If purchasing becomes organised through regional frameworks, exclusion from one arrangement could close off a much larger part of the placement market.

There is therefore a danger of a circular effect. Regional commissioning is intended partly to correct a market in which power has become concentrated among large providers. But if its frameworks and administrative expectations are easier for large organisations to satisfy, the solution could make it harder for smaller providers to survive.

We have seen this history before. Some smaller providers left the market. Others were sold or acquired by larger organisations. Acquisition and consolidation became part of the growth of corporate groups, including those backed by private equity.

A reform intended to reduce dependence on powerful large providers could therefore create further opportunities for consolidation.

That would matter for children as well as providers. When a smaller organisation disappears, local knowledge can disappear, experienced staff disperse, relationships end and specialist provision may be lost.

There is also a danger at the point of placement. Regional commissioning necessarily deals in aggregate demand, capacity, contracts and categories of provision. Children do not arrive as categories of regional demand.

A framework can identify an approved provider.

A block contract can secure capacity.

Neither can determine whether that placement is right for this particular child.

A contracted place is no more automatically a suitable placement than an empty bedroom is.

Nor should purchased capacity begin to determine which placement is used. The question must remain: what does this child need?

Regional Care Cooperatives should therefore be judged not only by what they purchase and what it costs, but by what happens to local knowledge, provider diversity and genuine placement choice after their purchasing power is exercised.

That is also why commissioning belongs within a workforce review. Commissioners help determine which organisations survive, what services they can provide and therefore which workforces can be recruited, retained and developed.

Changing commissioning can change the workforce without changing a single workforce regulation.

Scrutiny is not an evaluation

Evaluation is only one part of the test.

Here, scrutiny does not mean inspection of providers or operational oversight of individual services.

It means scrutiny of the policy decision itself and of the public money committed to it.

Parliamentary committees and the National Audit Office have examined important parts of children's social care. That scrutiny matters. But scrutiny after major decisions have been taken cannot substitute for proper appraisal before large-scale implementation.

The National Audit Office recorded that the Department for Education had originally decided against immediate national rollout of Regional Care Cooperatives because there was insufficient evidence of their potential benefits. It also found that the two pilots would not test the full commissioning model originally proposed. [173]

Government subsequently moved from two pathfinders to seven Regional Care Cooperatives covering more than 100 local authorities.

That chronology matters.

Where is the published appraisal comparing regionalisation with the alternatives?

Where is the published national consolidated business case setting out the assumptions, risks, counterfactual and the conditions under which the model would be altered, paused or stopped?

And where is the national, programme-wide financial scrutiny of the establishment costs, continuing operating costs, transition costs, local-authority liabilities and value for money of a regional structure intended to operate across England?

Policy appraisal asks whether the diagnosis is sound, whether the proposed solution follows from it, what alternatives were considered and what risks have been identified.

Financial scrutiny asks what is being spent, what is genuinely additional, what has been rebadged, what continuing liabilities are being created, what assets the public will own and what outcomes are expected in return.

Evaluation asks what happens once a policy is being implemented.

All three matter.

But they are not interchangeable.

Evaluation after implementation has begun cannot replace appraisal of whether the policy should have been pursued in the first place, or financial scrutiny before the money was committed.

Who carries responsibility for the public purse?

The financial cost of reform cannot be treated as incidental.

The wider political diagnosis matters here too.

Keir Starmer came to power in 2024 promising national renewal. He spoke of rebuilding public trust, restoring politics to public service and rebuilding a country in which too many people no longer believed life would be better for their children.

The government he led legislated for, funded and accelerated substantial parts of the present children's social-care programme.

Two years later, Andy Burnham offered another diagnosis.

His criticism reached beyond the government immediately before him.

On becoming Prime Minister, Burnham argued that Britain needed a new political model and a new economic model. He traced problems of centralisation, privatisation and de-industrialisation back over four decades and called for greater devolution, stronger public control and a more preventative approach.

That matters to this review.

Blair sought to reform the system he inherited.

Cameron sought to reform a system Blair had already changed.

Starmer sought to rebuild after fourteen years of Conservative government.

Burnham now argues that some of the structures and assumptions accumulated across successive governments are themselves part of the problem.

Each government therefore inherits not only problems identified by its predecessors, but the consequences of the solutions those predecessors introduced.

Children's social care is no exception.

Reform enters a system with its own history, knowledge and experience.

It enters a system already changed by previous legislation, reorganisations, professional reforms, regulatory decisions, commissioning arrangements and attempts to solve earlier problems.

That creates another question for the reforms examined in this review.

What part of the problem government is now trying to solve was created, intensified or displaced by an earlier attempt to solve something else?

On 20 July 2026, Andy Burnham became Prime Minister. He therefore inherited not only the programme begun under Starmer, but responsibility for what government does with it next. [178]

Political sponsorship of reform must include accountability for the evidence used to justify it, the money committed to it and the consequences that follow.

Power to reform should not become power to avoid accountability for the reform.

In May 2026 government identified £2.4 billion for the Families First Partnership Programme, £245 million for legislative commitments and care-market reform, and £560 million of capital funding to expand and refurbish children's homes. Taken at face value, those headline commitments amount to £3.205 billion. [175]

That is not the same as saying that £3.205 billion is entirely new or non-overlapping money. That is precisely why consolidated financial scrutiny is needed.

Government's own ten-year efficiency projections also expect children's social-care reform to deliver substantial savings, while acknowledging that some wider projected benefits are not yet sufficiently developed to model. [176]

Before further commitments are made, the public should be able to see in one place what the programme is expected to cost, which funding is genuinely additional, which announcements overlap, what continuing liabilities are being created, what savings are assumed, when they are expected and what evidence supports those assumptions.

The same scrutiny should follow capital funding.

What will the public own in return?

Will publicly financed assets remain public capacity?

What happens if a provider fails, withdraws, is acquired or sells an asset created with public money?

And the same scrutiny should follow new structures.

Regional Care Cooperatives require leadership, staffing, governance, data, commissioning and administration.

Their initial grants are not the final cost.

The question is not whether public money should be spent on children's social care.

It should.

The question is whether billions are being spent on reforms whose assumptions have been sufficiently tested, whose alternatives have been properly appraised and whose outcomes can be transparently judged.

A new structure is not an outcome.

A qualification is not an outcome.

A target for foster places is not an outcome.

A reduction in residential placements is not, by itself, an outcome.

The outcome is what happens to children, the relationships that survive, the stability they experience, the adulthood they reach and whether public money helped to achieve it.

From review chair to front bench

The government response to MacAlister did not simply adopt every recommendation of his review.

Stable Homes, Built on Love also responded to the Competition and Markets Authority's work and the national safeguarding review. Some recommendations were changed, deferred or rejected. [82]

That needs to be acknowledged.

But substantial elements of the direction proposed by the Independent Review continued.

Regional Care Cooperatives moved from recommendation to pathfinder implementation and then into accelerated rollout.

Family-help structures were redesigned.

Family-network approaches expanded.

Fostering recruitment became a major priority.

Residential workforce reform continued.

Professional registration remained under consideration.

And residential care became increasingly associated with a smaller, more specialised role.

Then another significant change occurred.

The person who had led the Independent Review became the Minister for Children and Families.

Josh MacAlister now has ministerial responsibility for children's social care, children in care, adoption, kinship care, fostering, Regional Care Cooperatives, care leavers and the children's social-care workforce.

The reviewer has therefore moved from recommending substantial changes to children's social care to holding ministerial responsibility for many of the policy areas through which those changes are being pursued.

That does not establish wrongdoing.

Nor does it mean that somebody who conducts a review should be prevented from subsequently entering government.

It creates a different question.

Where is the independent test between diagnosis, recommendation and implementation?

What is the review at liberty to discover?

The review team says its conclusions are not predetermined.

That should mean the evidence is capable of changing the direction of travel.

The review should be free to conclude that residential care should not be further reduced; that some children should enter it earlier; that it has multiple purposes; and that fostering cannot be treated as a simple family-based substitute.

It should be able to examine the professional, commissioned and commercial infrastructure of modern fostering, what regulation has done to residential care as well as what it has found within it, and whether any single therapeutic or pedagogical model should define good residential child care.

It should also be free to conclude that specialist provision requires spare capacity, that professionalisation should build upon existing residential knowledge, and that assumptions inherited from the Independent Review and subsequent reform programme need reconsideration.

Otherwise, the review is not testing the direction of policy.

It is helping to design the route towards a destination already chosen.

The concern is not that the review will recommend change. It is that the boundaries of permissible change may already have been drawn.

Follow the child

There is one idea from *Every Child Matters* that deserves to be recovered.

Follow the child's journey.

A child may receive help while living with their family.

Live with relatives.

Enter foster care.

Move again.

Return home.

Come back into care.

Live in residential care.

Need secure provision.

Move into a 16-plus service or supported accommodation.

Leave through adoption or another permanence route.

Return later.

Reach 18 and legally become an adult while continuing to receive leaving-care support.

Most children will not experience anything like that whole sequence.

That is exactly the point.

There is no single care journey.

Services are organised into categories.

Children live one life.

What did the child need?

What was offered?

What was unavailable?

What worked?

What failed?

Why did it fail?

What happened next?

Which needs were present at the beginning?

Which developed later?

What did repeated moves add?

What relationships survived?

What did the whole journey cost?

And might the right care at an earlier point have changed what followed?

Residential care cannot answer those questions alone.

Neither can fostering.

Neither can adoption, youth justice, family support or leaving-care services when they are examined as though the boundaries between them belong to the child rather than the system.

Neither can the regulator if it looks only at the service in front of it and not at the journey that brought the child there.

Follow the child, not the category.

The adults they become

There is one further body of evidence this history has to confront.

The lives of the adults who spent time in care as children.

But the question is not simply what their outcomes were.

It is what impact the whole journey had upon them.

Adults who spent time in care as children are overrepresented when compared with the general population in some forms of later disadvantage. That does not mean that most adults who experience homelessness, imprisonment, unemployment or poor health spent time in care as children.

Those patterns matter.

But they are not the whole story.

Those differences need to be understood. They do not tell us why they exist.

Longitudinal research has found associations between having spent time in care and poorer health and premature mortality later in life. Those findings cannot simply be dismissed as the consequence of social disadvantage before care. But neither do they establish that being in care caused the later outcome. The children included in that research experienced different versions of the care system over several decades, and the placement in which a child was recorded cannot tell us everything that happened before they arrived there, what happened within it or what happened afterwards. [139,140]

Nor does that research establish that kinship care is best for every child, that fostering is better than residential care, or where adoption should sit in that order.

The research relied upon to compare later outcomes did not compare kinship care, fostering, residential care and adoption on a like-for-like basis.

Different outcomes between groups do not prove that one form of care is better than another.

That distinction is becoming more visible in research published since the Independent Review.

The University of Liverpool Care Experience Study approaches the question differently. Its qualitative research examines both the system of care and the experience of living within it, rather than treating care status or placement type as sufficient to explain later mental health. [203,204]

It moves the inquiry from placement type to the experience of care itself.

That is important because children within the same placement category can have profoundly different experiences. If instability, loss, fear or conditional care contribute to later harm, the relevant question is not simply whether the child was in kinship care, foster care or residential care. It is whether those things happened to them, what protected them from earlier harm, and what may have added to it.

The placement tells us where the child lived. It does not tell us what the child experienced there.

Good care may provide safety, relationships and an opportunity to begin living with what happened before care.

Poor care may fail to do that.

And some experiences within care may add another layer of adversity to what the child was already carrying.

That is why adult outcomes cannot be understood from the administrative category alone.

Population statistics show that adults who spent time in care as children are overrepresented in some forms of later disadvantage.

That makes the adult life part of the evidence we need to understand, not simply another outcome to be counted.

But the administrative fact that somebody spent time in care cannot explain those differences on its own.

We have to understand the journey that sits behind it.

Having been in state care is an administrative history. It does not tell us which experiences within that history contributed to the adult life that followed.

We also see people achieve remarkable things.

And we see everything in between.

People build families, careers, friendships and communities. They become parents, caregivers, professionals, artists, campaigners and leaders. Most live lives that will never appear in a public inquiry, a newspaper or a memoir.

Every story is unique.

That is another reason to remember the principle recognised in 1948. Spending time in care is part of a person's history. It should not have to become the identity through which the rest of their life is understood.

Every story adds to the inquiry.

Some tell us about abuse and neglect before care.

Some about safety found within it.

Some about relationships that endured for a lifetime.

Some about repeated moves and relationships repeatedly lost.

Some about belonging.

Some about never quite finding it.

Some tell us about opportunity.

Some about opportunities denied.

Some about gratitude towards the people who cared for them.

Some about anger towards the institutions that did not.

Some tell us about enduring anger, injustice and harm that was never acknowledged.

Some about identity and the need to understand where they came from.

Some about the importance of one adult who remained.

Some about the lifelong consequences of nobody remaining.

And many contain several of those things at once.

First-person accounts make that diversity visible.

They were written at different times, but more importantly they describe childhoods lived within different versions of the care system.

The law changed.

The institutions changed.

The balance between fostering and residential care changed.

Professional roles changed.

Regulation changed.

Expectations of children and caregivers changed.

The adult looking back is therefore not simply telling us about “care”. They are telling us what it was to be a child within a particular version of the care system.

Fatima Whitbread, Andrew Adonis and David Jackson take us into an earlier period when residential care occupied a much larger place within the system. [143]

Their stories are different.

Fatima Whitbread has spoken about the difficulties of institutional childhood, but also with warmth about residential workers who mattered to her.

Andrew Adonis has described practitioners who knew him well enough to believe that the usual options did not fit him and who persisted in arguing for something different.

David Jackson’s published account provides another perspective on a childhood lived across different parts of the care system, through significant legislative change, and on the impact carried into adulthood.

These are not simply stories of people who later did well.

They remind us that residential workers could know children, form relationships that mattered, exercise judgement, advocate and sometimes alter the direction of a child’s life.

The history of residential care is not only a history of what adults did to children. It is also a history of what some adults did for them.

Samantha Morton belongs to a later generation. [145]

By the time she experienced substantial periods of care, fostering had become the preferred placement for many children and residential care had already been substantially reduced.

Her account moves between foster care and residential care.

That matters.

Policy can record one placement as fostering and another as residential care.

The child experiences one childhood containing both.

Morton’s later life also shows why remarkable achievement should not be confused with absence of impact.

She has used the platform created by her success to speak directly to children in care and to challenge the system in which she grew up.

Her later success did not prevent her from continuing to speak critically about that system.

Nor did it turn what happened into a simple story of overcoming adversity.

Some adults remain deeply angry about what happened to them.

Some believe the institutions responsible for protecting them failed, that what happened was never adequately acknowledged, or that the same failures continue for another generation.

That anger can endure alongside successful careers, families, relationships and contribution.

Success does not erase impact.

Ben Ashcroft's *Fifty-One Moves* takes us into another journey again. [146]

Its importance lies not simply in the number of moves named in the title, but in what repeated movement allows us to see.

A placement ends.

A relationship ends.

Another begins.

The child moves again.

His story sits alongside the evidence examined earlier in this review about children reaching residential care after repeated placement breakdown.

The personal account and the statistical evidence are not the same thing.

But both warn against beginning the story at the final placement.

Fostering has its own first-person history.

Lemn Sissay's account crosses long-term fostering and residential care and later returns to questions of identity, records and decisions made by adults around him. [147]

Again, the administrative categories cannot contain the journey.

A long period in foster care does not become a separate childhood when residential care follows it.

Nor does the later placement erase what came before.

Ashley John-Baptiste offers another perspective. His account also crosses foster and residential care, but he has described the positive impact of a later foster family whose nurture, inclusion and expectations around education changed what he believed was possible. He later described the difference a good foster parent can make as "world changing." [150,151]

That does not make his care journey a simple success story.

It shows why positive fostering relationships belong in the evidence too.

A placement category cannot tell us whether a child experienced belonging. The child's account can.

Adoption adds another dimension.

Jackie Kay and Jeanette Winterson were both adopted as babies, but their accounts describe very different adoptive childhoods. [148,149]

Kay has written about love and belonging within her adoptive family while also exploring race, identity, origins and the need to understand where she came from.

Winterson describes a very different childhood, shaped by an intensely religious home and a troubled relationship with her adoptive mother.

Neither account tells us whether adoption "works".

They show why the question is too simple.

An adoption order creates legal permanence.

It does not determine the quality or impact of the relationships lived within it.

A child can belong deeply within an adoptive family and still need to understand their origins.

Another can experience legal permanence without emotional safety.

The category was the same. The childhood was not.

The same principle applies across fostering and residential care.

A foster placement can provide belonging or another rejection.

A children's home can expose a child to harm or contain the adult who knows them well enough to fight for their future.

One childhood may contain several of those experiences.

The label does not determine the impact.

Nor does one story cancel another.

A story of good care does not disprove a story of abuse.

A story of abuse does not establish that all care was abusive.

A story of remarkable achievement does not erase harm.

A story of later difficulty does not establish that care caused it.

A person may feel gratitude towards one adult and anger towards the institution that employed them.

They may describe care as lifesaving and still carry loss from it.

They may succeed and still carry its impact.

They may forgive without forgetting.

They may remain angry because acknowledgement or accountability never came.

Every story is unique. Every story adds to the inquiry. No single story is the story.

Being recorded as having been "in care" therefore tells us very little about the childhood actually lived.

It tells us that, at some point, the state assumed particular responsibilities towards that child.

It does not tell us why the child entered care.

At what age.

What happened before they arrived.

Whether they lived with relatives, foster carers or residential workers.

Whether they remained in one home or moved through many.

Whether they returned home.

Whether placements broke down.

Whether they entered secure care.

Whether they were adopted.

Who remained in their life.

Or what happened when they left.

The 2026 review of early deaths makes the same problem visible.

Its mortality comparison was not like-for-like, something the authors themselves acknowledged. The 112 notifications related to care leavers aged 18 to 24 during 2025, while the population and general mortality figures used for comparison came from different periods and age groupings. [142]

Nor did the published analysis reconstruct the complete care journeys of all 112 young people.

The detailed cases show why that matters. One young person entered care at six, spent four years with one nurturing foster carer and then experienced more than ten foster placements before adulthood. Other lives crossed foster care, residential care, supported accommodation, mental-health services, homelessness, prison and family relationships.

“Care leaver” does not describe those journeys.

The review was not designed as a longitudinal or epidemiological study. It was commissioned to understand the circumstances around these deaths and identify learning for policy and practice. That distinction matters when its findings are used to explain why young people who had been in care died early.

Nor does the category tell us which care system they experienced.

A child entering care in the 1950s did not enter the same system as a child entering in the 1980s, 2000s, 2020s or today.

Even within one childhood, the policy framework could change around the child.

Care is therefore not a single intervention whose effects can simply be measured against adulthood.

It is a journey.

And there is no single care journey.

The adult life contains what happened before care.

What happened during care.

And what happened afterwards.

It contains relationships, separations, opportunity, loss, belonging, rejection, health, education, family, community and chance.

Population evidence remains important because persistent overrepresentation in vulnerable adult groups demands explanation.

But individual lives tell us something aggregated data cannot.

They tell us how things were experienced.

What mattered.

What endured.

What helped.

What harmed.

What was repaired.

What was never repaired.

And what people themselves believe should have been learned from what happened to them.

There is another reason the adult perspective matters. NICE noted that care leavers frequently seek access to their health and social-care records in order to make sense of their journey through care. It also recognised that depersonalising or judgemental language in those records can itself cause emotional hurt. [193]

The record is therefore not simply evidence about the childhood. It may later become part of how the adult tries to understand it.

Adult lives are therefore not simply outcomes to be counted. They are evidence of impact.

If we want to know whether children's social care has achieved what it intended, we have to follow the journey further.

Success cannot simply mean that a child did not enter residential care.

That a foster placement was made.

That an adoption order was granted.

That a child returned home.

That a young person moved into supported accommodation.

Or that a case was closed.

Those are events in a life.

They are not the life.

The longer questions are different.

Did the child grow into an adult with people who remained?

Did they have somewhere they belonged?

Were they able to learn, work and build relationships?

Did they have somewhere safe to live?

Could they become a parent without their own childhood continuing to determine how the state saw them?

Did the care they received help them live with what happened before care?

Or did what happened within care add another layer to it?

And when difficulties emerged later, was there anybody still there?

Care is not a single story.

Residential care is not a single story.

Foster care is not a single story.

Adoption is not a single story.

And "in care" is not a single childhood.

And "care experienced" is not a single identity.

The lives of adults cannot give us one verdict on whether care worked.

But every life adds something to the inquiry into what happened, what mattered and what the system should have learned.

The system records a care history. The person lives a childhood.

The categories belong to policy.

The journey belongs to the child.

Before the purpose of residential child care is defined

Residential child care cannot escape its history.

Nor should it.

That history includes abuse. Children were harmed. Some workers abused their authority. Poor practice existed and some organisational cultures protected what should have been challenged.

Those things should not be minimised.

But neither should they become the whole history.

Many practitioners cared deeply, knew children well, advocated for them and exercised judgement on their behalf. Some challenged the systems that employed them when those systems did not serve the child.

Professionalisation should therefore not begin with an assumption that knowledge has to be imported into a workforce that has none. It should ask what knowledge already exists, what has been lost, what needs strengthening and what history has already taught us.

The larger history shows that residential care has never developed in isolation.

The 1948 settlement placed residential care, fostering and aftercare within one specialist child-care responsibility. Later reforms dismantled specialist Children's Departments, changed youth justice, strengthened permanence planning and adoption, expanded specialist fostering, created new boundaries around leaving care and supported accommodation, changed who provided care and moved regulation into Ofsted.

Each change altered what happened somewhere else in the system.

Residential care was substantially reduced.

Fostering became the dominant placement.

Government was warned that residential capacity had been reduced too far.

The mixed economy was not preserved.

Fostering itself became professionalised, commissioned and increasingly commercial.

Illegal children's homes later exposed what can happen when suitable lawful capacity is not available.

The workforce now being reviewed did not create the system in which it works.

Government designed policy.

Legislation and regulation created roles, responsibilities and professional boundaries.

Local authorities commissioned placements.

Providers developed services in response.

Markets grew.

Ofsted registered and regulated them.

Field social work acquired increasing professional status and authority while residential social work lost the professional identity it had once held.

Responsibility for how we arrived here cannot now be transferred to the workforce and presented as workforce reform.

People, ideas, professional language, practice, political ideology and regulatory assumptions all travel.

The important question is whether challenge travels with them.

Frontline's founder, Josh MacAlister, went on to lead the Independent Review of Children's Social Care. That review proposed Regional Care Cooperatives, changes to family help, professional regulation and new leadership routes within a direction in which residential care would become more specialised. Regional Care Cooperatives then moved from two pathfinders to seven, covering more than 100 local authorities, and MacAlister subsequently became the minister responsible for children's social care, fostering, Regional Care Cooperatives and the children's social-care workforce.

The issue is not that the architect of reform has remained involved. It is whether the assumptions underpinning that reform were independently tested against the historical evidence before implementation accelerated and its architect acquired ministerial responsibility for taking them further.

Some reforms are being evaluated.

That is necessary.

But implementation evaluation is not the same as historical challenge, and an early evaluation is not evidence that a model has worked.

Narey concluded in 2016 that there was very little scope to reduce reliance on children's homes further. Ofsted subsequently found children reaching residential care after repeated foster placement breakdown. The Competition and Markets Authority found shortages of suitable residential and fostering provision. Ofsted has acknowledged that more registered homes have not produced the right homes in the right places. Hundreds of children have lived in illegal homes because suitable lawful provision could not be found.

None of this produces one simple policy answer.

It demonstrates why children cannot safely be reduced to an administrative category, placement ideology, professional model or age threshold.

And yet government has already set a direction in which residential care becomes more specialised and is used for fewer children.

What is still not known

We do not know with sufficient confidence what the optimum balance between foster and residential care should be.

We do not know that 10,000 additional foster places can replace the residential placements government intends to reduce.

We do not know how many children currently living in residential care could successfully live within foster families if more placements existed, or how many would experience further breakdown before entering residential care anyway.

We do not have a settled evidence base demonstrating that residential care should become a smaller, more specialised sector used for fewer children.

We do not yet have evidence that Level 6 professionalisation will improve children's experiences and outcomes sufficiently to justify its consequences for recruitment, retention and cost.

We do not know whether a smaller specialist residential sector would remain sufficiently viable to maintain local provision and placement choice.

We do not know what happens to children who need residential care but do not meet a new threshold of complexity.

And we do not know the full human or financial cost when need is displaced into repeated foster placement breakdown, emergency provision, illegal homes, deprivation of liberty or secure care.

These are not peripheral uncertainties. They go to the heart of what government is proposing.

That is why this review of the residential workforce cannot simply ask how to train people for the sector government has already decided it wants.

It needs to ask whether the premise is right.

It needs to ask why residential child care is being reviewed in isolation, and whether fostering is being examined with the same rigour when the two are parts of one care system.

It needs to ask what more than forty years of preference for fostering has achieved, where it has failed and whether the professional, regulatory and commercial reality of modern fostering changes the comparison now being made.

It needs to ask what regulation has done to residential care as well as what regulation has found within it, including how illegal children's homes became normalised within a system in which government, local authorities, courts and the regulator all knew they were being used.

It needs to ask what happened to the findings of previous reviews and why major structural reform is being expanded while important evidence about its effects is still being gathered.

It needs to ask whether a smaller specialist sector could require children to become more complex before they can access it, and whether the organisations expected to employ a newly professionalised workforce can remain viable.

And it needs to ask whether contemporary therapeutic and pedagogical ideas build upon the knowledge residential child care already possesses, and whether those selected to help define its future represent enough of its history, knowledge and diversity, as well as the fostering, commissioning and regulatory systems with which it is inseparably connected.

Residential child care cannot choose which parts of its history belong to it.

Fostering should not escape its own history either.

Neither should Ofsted.

But neither government, providers, commissioners nor regulators should choose only the parts of history that support another round of reform.

The history of children's social care is also a political and institutional history. Children have lived through changing ideas about welfare, family, punishment, permanence, achievement, markets, professional authority, regulation and the role of the state. They have experienced those ideas not as ideology or organisational design, but as placements, moves, relationships, separations, opportunities and losses.

Children's social care cannot continue to behave as though a change made in one part of the system ends at the boundary of another.

Residential care and fostering are parts of one care system.

Both can provide important relationships.

Both can fail.

Neither should be judged by its label.

Adoption is intended to bring the care placement journey to an end for some children, but the consequences and relationships that preceded it do not simply disappear.

Youth justice, family support, permanence, leaving care and supported accommodation all intersect with it.

Commissioning shapes it.

Regulation shapes it.

Government shapes it.

And the child lives with the accumulated consequences.

The review of early deaths provides one final test.

More than one hundred deaths among young adults entitled to continuing support demand attention. But urgency does not remove the need to distinguish description, association and causation.

The review identified loneliness and isolation. It also described suicide, serious physical illness, murder, imprisonment, homelessness, mental-health difficulties and failures between children's and adult services. It did not reconstruct the complete care journeys of all 112 young people or establish loneliness as a single explanation for their deaths. [142]

What government commissions shapes the question that is asked and therefore the answer the inquiry is capable of producing.

A review can be independently conducted and still begin within a direction that has already been set.

That is the same test that applies to the present workforce review.

Is the evidence capable of changing the policy, or only of helping to develop it?

Before we redefine residential child care, there is a simpler place to begin.

Start with the child, not the placement ideology.

Then follow the child through the whole journey.

And follow the child into the adult they become.

And ask what the evidence has already taught us before we commission another answer.

Follow the child. Follow the history. Follow the money.

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