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Ofsted's second monitoring visit exposes deeper failures in Harrow Children's Services - with signs of deterioration

HMG article - 13 March 2026

Executive Summary

The second monitoring visit by Ofsted to Harrow's children's services (their letter of 12 March 2026) confirms what independent scrutiny by the Harrow Monitoring Group has warned for some time: the problems identified in early 2025 were not isolated weaknesses but symptoms of wider systemic failings. While leadership changes are under way, they remain too recent to influence practice, and the overall picture since the previous monitoring visit in September 2025 is not improvement but widening concern. The latest inspection has expanded its focus to fundamental issues of safeguarding and children's wellbeing, including the quality of assessment, planning and review, and the effectiveness of Independent Reviewing Officer (IRO) oversight, revealing gaps that mirror those long raised by the Harrow Monitoring Group. The result is a sobering conclusion: *despite formal intervention and public assurances, the experiences and progress of children in care have not been sustained and in some respects have deteriorated.*

The expanded inspection focus now confirms concerns long raised by independent scrutiny.

1. The second monitoring visit to Harrow's children's services marks a significant moment in the borough's prolonged struggle to restore confidence in a service once rated "good". When Ofsted judged the service "inadequate" in January 2025, the decision triggered a government improvement notice and an abrupt leadership crisis, including the departure of the director of children's services later that year. What followed, however, was not the decisive structural reset that such a judgement should have provoked. Instead, the council's response appeared cautious and incremental, while the deeper organisational weaknesses continued to shape frontline practice.

2. The latest monitoring visit therefore matters not simply as a routine check but because its scope has widened considerably. Unlike the January 2025 inspection and the first monitoring visit in September 2025, inspectors this time examined a broader set of safeguarding foundations: the quality of social work intervention, the quality of assessment, planning and reviewing, and the impact of Independent Reviewing Officer oversight. This shift reflects a recognition that the problems in Harrow's children's services are not confined to particular outcomes but extend to the basic architecture of care planning and professional accountability.

3. The headline conclusion is stark. Although new leaders are being appointed and corporate commitment to improvement has been expressed, these changes remain at too early a stage to influence frontline practice. As a result, inspectors conclude that the experiences and progress of children in care “have not been sustained since the last inspection”.

In effect, despite more than a year of scrutiny and intervention, the service has yet to demonstrate that it can consistently translate leadership intentions into improved outcomes for children.

4. This widening concern echoes warnings previously raised by the Harrow Monitoring Group. Its submissions and analyses have repeatedly highlighted weaknesses in the quality of assessments, the coherence of care planning and the practical limits of relying on Independent Reviewing Officers to compensate for systemic shortcomings. The Ofsted findings now reinforce that diagnosis: *IRO capacity is stretched, and reviews have become increasingly process-driven rather than focused on the quality and impact of decisions for children.*

When oversight mechanisms themselves struggle to function effectively, the entire safeguarding system loses an essential line of challenge.

5. The consequences are not abstract administrative problems; they translate directly into instability in children’s lives. Inspectors found inconsistency in the timeliness of decisions about when children should enter care. Some children wait too long before being brought into care, while others move repeatedly between home and care before a final decision is reached. Such delays create uncertainty and instability at precisely the moment when children most need clarity and safety.

6. Planning weaknesses compound these difficulties. Gaps between safeguarding teams and children-in-care teams mean that some children arrive in the care system with incomplete or poorly considered plans, requiring later amendment. Even seemingly administrative adjustments, such as changes to arrangements for family contact, can disrupt routines and undermine the trust children place in professionals meant to support them.

7. The inspection also reveals a troubling erosion of practices that were previously strengths. Life-story work, which helps children understand their journey into care and develop a coherent sense of identity, was highlighted positively at earlier inspections. Yet it is now inconsistent, and in adoption cases life-story materials are sometimes unavailable when children are placed with adoptive families.

The decline of such work illustrates how service instability can gradually weaken elements of practice that once supported children’s emotional wellbeing.

8. The role of Independent Reviewing Officers illustrates the structural dimension of these problems. In theory, the IRO function provides independent oversight, ensuring that care plans are properly implemented and challenged where necessary. In practice, inspectors found that capacity pressures mean reviews focus on completing actions rather than evaluating whether

those actions genuinely improve children's lives. Virtual meetings, limited direct contact with children and insufficient time for challenge reduce the effectiveness of this statutory safeguard.

9. Other systemic weaknesses reinforce the picture of a service struggling to maintain coherent oversight. Some children are living in unregistered accommodation with insufficient monitoring of their safety and welfare. Others experience long delays in accessing mental health or neurodiversity assessments, leaving important needs unmet and sometimes threatening placement stability.

These are not isolated failures but indicators of a system where coordination across services and agencies is inconsistent.

10. Permanence planning, the process intended to secure stable, long-term homes for children, also remains fragile. Inspectors found that many plans lack urgency and detailed actions, while some children's permanence plans are simply recorded as "other" due to unresolved data issues. Oversight of permanence is fragmented, weakening scrutiny and delaying children's transition into homes that can offer lasting stability.

11. Taken together, these findings suggest that Harrow's children's services have not merely struggled to improve since the first monitoring visit; in some areas the system has lost further ground. The inspection does acknowledge committed social workers and some positive structural steps, including the creation of a standalone children-in-care team. Yet these incremental improvements sit alongside deeper operational weaknesses that continue to shape children's experiences.

12. The broader lesson is uncomfortable but necessary. Local authorities cannot rely on inspection cycles or leadership reshuffles alone to restore failing services. Sustainable improvement requires a clear acknowledgement of systemic weaknesses and a willingness to confront them openly. For too long, Harrow's leadership narrative has emphasised partial successes or technical explanations rather than addressing the full scale of the problems exposed in inspection reports.

13. The second monitoring visit therefore performs a valuable public function. By examining assessment quality, care planning and IRO oversight in greater depth, it exposes the operational foundations on which safeguarding depends. The Harrow Monitoring Group's earlier warnings about the fragility of these foundations now appear prescient.

14. What matters now is whether the council responds with the urgency and transparency the situation demands. Children in care cannot wait for organisational cultures to adjust gradually or for leadership teams to settle into new roles. Their need for stability, safety and permanence is immediate. If the latest inspection demonstrates anything, it is that improvement delayed is improvement denied, and that the cost of such delay is borne not by institutions, but by the children they exist to protect.

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