Safeguarding children

The third joint chief inspectors' report on arrangements to safeguard children

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Christine Gilbert
Her Majesty's Chief Inspector

The Rt Hon Ed Balls MP, Secretary of State for Children, Schools and Families
The Rt Hon Des Browne MP, Secretary of State for Defence
The Rt Hon John Denham MP, Secretary of State for Innovation, Universities and Skills
The Rt Hon Alan Johnson MP, Secretary of State for Health
The Rt Hon the Baroness Scotland of Asthal QC, Attorney General
The Rt Hon Jacqui Smith MP, Secretary of State for the Home Department
The Rt Hon Jack Straw MP, Secretary of State for Justice and Lord Chancellor

The third joint Chief Inspectors' report on arrangements to safeguard children

On behalf of eight inspectorates, I am pleased to present the third joint Chief Inspectors' report on arrangements to safeguard children. This draws on individual and joint inspection activity; it follows the two previous reports published in 2002 and 2005.

We report many improvements over the past three years and these sit securely within the changing landscape of children's services underpinned by the Children Act 2004 and the Every Child Matters agenda. However, we also identify a number of recurring issues which indicate that some children are still not well enough served by public services.

We make a number of recommendations to improve safeguarding arrangements for children and young people. If implemented, these would support the ambitions of the Children's Plan and lead to improvements in the quality of life for children and, indeed, their families.

We urge you to consider the recommendations with speed.

Yours sincerely

Christine Gilbert CBE, Her Majesty's Chief Inspector of Education, Children's Services and Skills

On behalf of:
Anna Walker CB, Chief Executive, Healthcare Commission
Paul Snell, Chief Inspector of the Commission for Social Care Inspection
Sir Ronnie Flanagan GBE QPM, Her Majesty's Chief Inspector of Constabulary
Stephen J Wooler CB, Her Majesty's Chief Inspector of the Crown Prosecution Service Inspectorate
Eddie Bloomfield, Her Majesty's Chief Inspector of Court Administration
Anne Owers CBE, Her Majesty's Chief Inspector of Prisons
Andrew Bridges, Her Majesty's Chief Inspector of Probation

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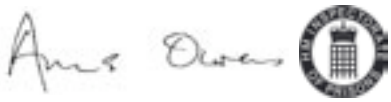

Anne Owers CBE,
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Introduction

This is the third report of the joint chief inspectors' review of arrangements to safeguard children. The two previous reports were published in 2002 and 2005. The second *Safeguarding children* (2005) report had three main findings:

- The priority given to safeguarding across agencies had increased since 2002 and children's views were being taken into account more widely. Agencies were also working together better to identify and act on welfare concerns.
- Policy commitments to safeguarding were not always reflected in practice and some agencies, especially in the justice system, did not give sufficient priority to safeguarding children.
- There were specific concerns about arrangements for particular groups of children, including looked after children,[1] children with disabilities and some children in health and secure settings.

Much has changed in the landscape of children's services since the previous report. In particular, there is a greater emphasis on safeguarding all children and improved inter-agency support for children in need of protection from abuse or neglect. Most of the provisions of the Children Act 2004 are now fully in force and the framework supporting the Every Child Matters: Change for Children programme is largely in place. Procedures for vetting people who work with children and for joint working to act on welfare concerns have been, or are in the process of being, strengthened. There is increasing recognition in the National Health Service (NHS) of the importance of the safeguarding children standard in the National Service Framework for Children, Young People and Maternity Services. Legislation is in hand to improve care services for children and young people, and the Government is giving attention to improving the experiences of asylum-seeking children.

Inspection arrangements for children's services at local authority level have also changed significantly since 2005. Evidence in this report comes from the annual performance assessment (APA) of each local authority's children's services. It also comes from the programme of joint area reviews (JARs) carried out by a range of inspectorates working together in each of the 150 upper tier local authority areas in England.[2] This inspection activity has looked at how well services work together to improve outcomes for children and young people. In addition, the report draws on a wealth of evidence from other targeted and mainstream inspections. It refers to a wide range of published material about safeguarding children.

The definition of safeguarding itself has developed since the first review was published in 2002. At that time, many services saw safeguarding as commensurate with child protection. Since then, there has been a discernible shift to a wider view of safeguarding and of the role of public services in promoting the welfare of children and young people. The Government has defined the term 'safeguarding children' as:

> 'The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.'[3]

Adopting this wider definition, this report looks at arrangements for safeguarding children and young people in four key areas:

- the effectiveness of the overall safeguarding systems and frameworks that are in place
- the wider safeguarding role of public services
- the targeted activity carried out to safeguard vulnerable groups of children; this includes updated evidence on the groups considered in the previous report, including asylum-seeking children, children in secure settings, looked after children and children treated by health services
- the identification of and response to child protection concerns by relevant agencies.

The report highlights what has improved over the past three years and assesses to what extent the considerable activity that has taken place at both national and local levels has affected outcomes for children. It also identifies those areas that are still in need of improvement.

Note: Unless otherwise specified, where 'areas' are referred to throughout this report, they are the 150 local authority areas in England with responsibility for providing council services for children and young people.

Executive summary

The third review of arrangements for safeguarding children covers a broader range of topics and is based on more extensive inspection evidence than the previous two *Safeguarding children* reports. New arrangements for the integrated inspection of children's services were introduced in 2005, when the last review was published. Since then, the inspectorates with a remit in this field have carried out wide-ranging joint area reviews. Individual inspectorates have also continued to carry out in-depth inspections of specific topics or particular services. The different types of inspection are carried out using approaches that are tailored to the topics and services involved, and inspectorates use different judgement frameworks for assessing and reporting on performance. They mostly support and confirm each other's findings. On occasion, however, differences in findings arise between joint area reviews and other types of inspection. The report draws attention to these variations wherever this is the case.

The report shows that much has changed since 2005 and provides evidence of improvements in children's services and in outcomes for children and young people. In particular, there is a greater emphasis on safeguarding all children and improved inter-agency support for children in need of protection from abuse and neglect. Every Child Matters: Change for Children, the Children Act 2004 and a range of other initiatives have provided a much-needed impetus for change. Most children feel safe, and are safe, in their homes and communities. However, there are still serious concerns that some children are not well served and these children need particular attention to ensure that they are properly safeguarded. As in 2005, this includes some children who are looked after, children who are asylum seekers and children and young people in secure settings.

The safeguarding framework

This chapter assesses the framework for safeguarding children that is now in place, the effect it has had on outcomes for children and young people and the improvements that are still needed. Much of this framework has changed significantly following the implementation of the Children Act 2004 and the Every Child Matters programme.

Local Safeguarding Children Boards (LSCBs) are in place and demonstrate greater independence in their chairing and reporting arrangements than when they were first established in 2006. They are beginning to focus on a wider safeguarding role in addition to child protection. A survey carried out in 2007 shows the following:

- Some statutory partners are not yet involved in the work of LSCBs in all areas. These include Connexions services, Cafcass and the Youth Offending Service.
- Few LSCBs are giving high priority to targeted activities to safeguard specific vulnerable groups; these include looked after children, those in private fostering arrangements, asylum-seeking children in the community and in short-term holding centres and immigration removal centres, children in mental health settings and children in secure settings, especially when placed outside their area.
- LSCBs are not yet in a position to demonstrate the impact of their work, since few have set themselves measures of their impact on safeguarding.

Strategic partnerships for delivering services to safeguard and promote the welfare of children are established in all areas. Agencies work together better to safeguard children than they did in 2005. Every Child Matters is providing a cohesive framework for joint working. There are several areas for improvement:

- Joint commissioning of services for all children in need is under-developed.
- The time-limited nature of some funding arrangements constrains the development of joint services. Examples include social worker posts in prisons and youth inclusion programmes, which have achieved positive results.
- The extent to which relevant agencies work together to safeguard children and young people through local multi-agency public protection arrangements (MAPPA) to manage the risks posed by sexual and violent offenders varies. For example, MAPPA are not represented on all LSCBs; there is a lack of clarity about the role, function and responsibilities of Youth Offending Teams (YOTs) in MAPPA; and prison staff attendance at MAPPA reviews in the community varies.

There is now much greater awareness of the need for and importance of **Criminal Records Bureau (CRB) checking** for staff whose jobs bring them into contact with children. Agencies comply well overall with legal requirements for CRB checking for new recruits. However, there is inconsistency in the extent to which agencies follow best practice, particularly with regard to:

- the extent to which checks are carried out or updated on staff who have been in post since before the requirement for CRB checks was established in 2002; this particularly applies to staff in NHS trusts and youth offender institutions
- re-checking of staff who have been CRB checked on appointment but who have not been re-checked after three years, which is accepted good practice.

The wider safeguarding role of public services

Agencies that work with children and young people have a wider role than simply protecting them from neglect and abuse. This role involves keeping them safe from accidents, crime and bullying and actively promoting their welfare in a healthy and safe environment. This chapter considers how agencies interpret and carry out this wider safeguarding role in different settings and services.

Inspections found evidence of a strong commitment by agencies to focus on the **wider safeguarding needs** of children and young people in addition to child protection. This is reinforced by the increasing integration of children's services and the shared framework provided by Every Child Matters. However:

- a shared, consistent understanding of safeguarding is still lacking, particularly between social care services and the criminal justice system
- there is a lack of a common approach to safeguarding across secure establishments (secure training centres and youth offender institutions), where the focus is disproportionately on containment and does not apply a proper balance between security and welfare needs.

The majority of settings where children are cared for or educated comply with requirements and regulations for **keeping children safe**. Inspections also found examples of good partnership working to prevent accidents to children. However:

- some children and young people continue to express significant levels of concern about their personal safety and about being bullied, particularly in institutional and secure settings
- there are concerns about standards of safety for children and young people in some fostering services, 10% of children's homes and most of the youth offender institutions that hold boys.

There is better identification of needs at an early stage and increasingly effective provision of **preventive and earlier intervention services**. These include services provided by children's centres and preventive services to tackle substance misuse by children and young people. Key areas for improvement include:

- The continuity of funding for some preventive services, such as sex education, is uncertain, which constrains service provision.
- Dedicated programmes have started to reduce the incidence of teenage pregnancy, but have yet to make a significant impact on teenage pregnancy rates.
- Drug and alcohol misuse remains a significant factor in offending behaviour but young people leaving custody may fail to access mainstream substance misuse services since work carried out in custody is not consistently available or always followed up in a timely way.

Most areas consider that they are making progress towards comprehensive provision of **mental health services** for children and young people (child and adolescent mental health services – CAMHS). Service provision is increasingly appropriate to the age of the children concerned and children's centres are helping to promote mental and emotional health. There remain significant shortcomings:

- a shortage of suitable hospital beds for children in some areas and long waiting times for access to services
- limited access to secure mental health beds for children and young people in custody, who often have to wait several months to be assessed
- a continuing lack of adequate provision for children and young people with learning difficulties and/or disabilities.

Many areas have identified **domestic violence** as a high priority area for action. Joint working arrangements to combat domestic violence have been strengthened, particularly between the Crime and Disorder Reduction Partnerships, children's services, the police and health services. The police, Probation Service and the Crown Prosecution Service (CPS) have clear arrangements for dealing with cases of domestic violence. However:

- a fifth of LSCBs identify combating domestic violence as a high priority but have yet to demonstrate the impact of their work on outcomes for children and young people

- responses by the probation service to the needs of children and young people who commit offences and who have a background of domestic violence were judged inadequate in half the cases reviewed
- there are significant variations in the knowledge and understanding of domestic violence among practitioners in the Children and Family Court Advisory and Support Service (Cafcass), which has a role in identifying and safeguarding children who are affected by domestic violence.

Safeguarding groups of vulnerable children

This chapter considers groups of children who are particularly vulnerable and/or need targeted interventions or special services. It shows what has changed since the previous *Safeguarding children* report in 2005 and what remains to be done to ensure that these children are adequately safeguarded. The chapter concludes that, despite the evidence of improvements, there has been slow progress for some groups of children. Furthermore, considerable concerns persist about the welfare of asylum-seeking children held in immigration removal centres and children and young people in custodial settings.

Inspections have identified improvements in the safeguarding of **looked after children and care leavers** since 2005. These include: better planning of placements in care and greater stability of placements; a reduction in out-of-area placements; more effective health monitoring; and increasing allocation of children to named and qualified social workers. However, some children are still not well served and improvements are needed in the following areas:

- One in 10 children's homes and fostering services are judged to be inadequate in keeping the children in their care safe. Inspections highlight the lack of experienced and competent staff and insufficient compliance with requirements for the supervision of staff.
- The choice of placement remains limited for most children and some children feel it is hard to influence decisions that involve them.
- Rates of educational attainment and school attendance remain unacceptably lower for looked after children than for other children.
- Children and young people in most areas continue to experience frequent changes of social workers. The lack of continuity has an adverse effect on the implementation of their care plans.
- Some looked after children and young people who go into custody subsequently have less contact with their allocated social worker than required or expected; this was the case in one in six YOT areas inspected. This is a particular problem where children are in custody a long distance from their home area.
- Social workers in prisons have provided support to looked after children and young people and have started to liaise well with other services. The uncertainty about continued funding for these posts significantly constrains their future development.
- There is a lack of suitable accommodation for care leavers and young people leaving custody in most local authority areas.

Organisations are working together better to identify **children and young people who go missing** from home, care or education and to deal with the underlying causes when they run away. However, no single agency has responsibility for maintaining reliable statistics on the numbers of children involved and information about the scale of the problem is fragmented and collected inconsistently.

Recognition of the needs of **young carers** has increased in children's services and in schools and support for them to attend school and leisure services has improved. However, processes for identifying young carers are underdeveloped, which makes it difficult to plan capacity to meet the potential demand for services.

Since 2005, attention to safeguarding at a strategic level within Cafcass has increased. Cafcass has also made progress in increasing the participation of children and in strengthening the voice of **children in family justice proceedings**. However, the quality of front-line practice in two Cafcass regions has recently been judged to be inadequate, posing potential risks to some children.

Improvements in witness care have benefited **children who attend court as victims and witnesses** and the courts treat child witnesses with care and sensitivity. However, inspections found that there is little systematic consideration by YOTs and probation services of the specific needs of children as victims.

Youth specialists in the Crown Prosecution Service (CPS) normally prosecute the cases of **children and young people who have committed an offence** and their handling of these cases is mostly satisfactory. Inspections also found many examples of good practice in YOTs' direct work with children and young people who offend. However:

- inspections raise continuing concerns about the length of time young people spend in court custody facilities before being transported to a secure setting
- assessments by YOTs of the needs of young people who offend often lack rigour and are not informed by home visits in a significant minority of cases
- concerns remain about the adequacy of health services for children and young people who offend, who are more likely to have physical and mental health needs than other children
- access to therapeutic treatment for young people convicted of a sexual offence is limited, particularly for young people in custody
- access to and sustaining of both statutory education and post-16 education, training and employment for children and young people who offend are inconsistent
- the needs of children and young people with learning difficulties who offend are not well identified or catered for.

Inspections have reported improvements since 2005 in arrangements for safeguarding **children and young people in secure settings**. These include: more robust child protection procedures; better communication between YOTs and youth offender institutions; and the introduction of social workers in youth offender institutions. Nonetheless, considerable concerns remain about the welfare of young people in these settings.

- The recommendation from the second *Safeguarding children* (2005) report concerning the use of restraint on children and young people has not been implemented. Restraint techniques currently in use still vary between different types of setting and some rely on pain compliance.
- Other security and disciplinary measures applied to children and young people in youth offender institutions, including routine strip-searching without sufficient assessment of risk, are based on the risks posed by adult prisoners and are inappropriate for children and young people and do not take sufficient account of the specific vulnerabilities of children.
- Children placed in secure settings at long distances from their homes are less well monitored than those placed within their home local authority area.

Most NHS trusts (95%) comply with the National Service Framework core standard for safeguarding **children and young people who use health services**. The majority of hospital trusts admit children to child-only wards and nearly all have made progress in providing child-friendly environments, appropriate security and play areas. Concerns remain in the following areas:

- the lack of priority given to children's safeguarding by some NHS trust and primary care trust (PCT) boards
- the extent to which health staff receive training in child protection
- the maintenance of skills in treating children by specialists including surgeons and anaesthetists.

Agencies are working together better to provide services across health, education and social care for **children with learning difficulties and/or disabilities**. Early needs identification for very young children is mostly good and multi-agency assessment has improved. However, access is limited to specialist therapeutic and respite services, speech and language therapy, CAMHS, special equipment, and services for children with attention deficit hyperactivity disorder or autism.

Since the previous *Safeguarding children* (2005) report, there is greater recognition of the support and safeguarding needs of **asylum-seeking children**, especially those who arrive unaccompanied. Nationally, this is demonstrated by recent policy developments that aim to improve support. Locally, inspections have found good, targeted services in the community, especially in health and CAMHS. Concerns remain that:

- arrangements for the protection and care of children in short-term holding facilities at airports are inadequate
- a few local authorities provide less support to looked after children and care leavers who are unaccompanied asylum-seekers than they do to other looked after children and care leavers in their area.

The two immigration removal centres in England that accommodate **asylum-seeking families with children** have made significant improvements in working relationships with local social services and in the handling

of childcare cases. Despite this, there are continuing concerns about the effects of detention in immigration removal centres on children's well-being and about delays in carrying out welfare assessments of these children. The Government did not accept the associated recommendations made in the previous *Safeguarding children* (2005) report. However, in the light of recent inspection findings, they are repeated in this report.

There is increasing recognition by local services of the varying needs of **children from minority ethnic groups**. A range of services is available for specific groups and there is increasing involvement of community and faith groups in planning services. However:

- in some areas assessments of the needs of individual children and young people sometimes fail to address specific needs relating to ethnicity
- surveys show that young people from minority ethnic groups feel that they have a worse experience of prison than young people who are white.

In the larger armed forces command units overseas, there are overseas social work teams and LSCBs to safeguard **children of armed forces families**. Inspection arrangements exist for schools and adoption services overseas. However, there is currently no overall inspection of how children of armed forces personnel overseas are kept safe or of the fostering service available.

Inspections of military establishments providing training for **young armed services recruits** show that the management of their safeguarding and welfare has improved considerably since 2005.

Child protection

Effective child protection is a fundamental part of safeguarding children and young people. The previous two *Safeguarding children* reports showed that considerable improvements were needed in this area. This chapter assesses what has changed since 2005 and how well revised arrangements for child protection are working.

Nearly all local authority areas have revised their **child protection procedures** in line with new guidance in *Working together to safeguard children*.[4] Some LSCBs have produced joint procedures. Access to procedures and guidance to staff is generally good across agencies. There are still areas for improvement:

- Inspections continue to raise concerns that some practitioners do not have sufficient knowledge and understanding of child protection. They include staff in the NHS who have not received basic or intermediate child protection training, some front-line staff of Cafcass and a few instances in YOTs.
- Child protection in prisons has improved, but there are still areas of concern. These include the thresholds applied for external investigations and the rigour of internal investigations into allegations arising from the use of force.
- In just under a third of cases, serious case reviews have been judged to be inadequate because of a lack of rigour in carrying them out. There are also serious delays in producing them in nearly all cases, some of which are avoidable. These factors limit the impact of serious case reviews on sharing the lessons and good practice arising from these cases and on improving practice.

Most local authorities have established clearer **thresholds** for access to children's social care services. Arrangements for the management oversight of front-line practice in children's services have also improved. Nearly all local authority child protection services are judged to be satisfactory or better. However:

- there is evidence that thresholds are still not well understood by referring agencies and thresholds are sometimes raised by local authority children's services in response to workload pressures, staffing shortages and financial resources
- the identification and management of children and young people in the criminal justice system who might be at risk or in need of additional support are less well-developed than in social care services. YOTs' pre-sentence reports were poor in assessing vulnerability in one in five cases inspected, while prisons do not assess vulnerability on a continuing basis
- lines of accountability and responsibility for child protection are not clear in all agencies, including some NHS trusts, Cafcass, YOTs, parts of the police service and youth offender institutions.

Most areas are making good progress in developing the

Common Assessment Framework (CAF). **Information sharing** between agencies on child protection or welfare concerns has improved at an operational level and there are well-established information-sharing protocols between many agencies. However:

- methods for assessing needs relating to safeguarding are not aligned with the national framework for assessment of children in need in all agencies. For example, the assessment framework used by YOTs, and the way it is applied, lacks rigour, as do assessment processes in Cafcass
- difficulties persist in parts of the NHS and throughout the youth justice system about sharing sensitive information on the needs of individual children and young people.

The provision of **child protection training** for staff across agencies is generally good and many agencies have made considerable investments in training. Despite this:

- some training, such as training for prison staff in juvenile awareness, does not cover child protection issues in sufficient depth
- access to child protection training for some groups of staff is limited. These groups include staff in schools, youth services and children's homes, GPs, prison staff, some YOT staff, and nurses and hospital specialists.

Recommendations

The following recommendations arise from the third joint chief inspectors' review of arrangements to safeguard children. They are intended to improve safeguarding arrangements for children and young people. They also aim to increase agencies' compliance with statutory requirements and associated guidance for safeguarding and promoting the welfare of children. Some of the recommendations are directed to central government departments[5]; others are directed to local agencies that provide children's services. The recommendations are grouped under the chapter heading from which they arise.

The safeguarding framework

All agencies

- All agencies that have a statutory duty to cooperate (local authorities, district councils, police, primary care trusts (PCT), NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should ensure that they are fully compliant in respect of statutory membership of Local Safeguarding Children Boards by 1 September 2008.[6]

Government

- The Department for Children, Schools and Families*, the Home Office and the Ministry of Justice should clarify the roles, functions and responsibilities of agencies contributing to multi-agency public protection arrangements (MAPPA) and ensure that relevant agencies meet them fully.

Local Safeguarding Children Boards

- Local Safeguarding Children Boards should ensure that robust quality assurance processes are in place to monitor compliance by relevant agencies within their area with requirements to support safe recruitment practices. These processes should include regular audits of vetting practice and random sampling of compliance with checks with the Criminal Records Bureau (CRB).

The wider safeguarding role of public services

Government

- The Department for Children, Schools and Families, the Department of Health* and the Ministry of Justice should increase and better target child and adolescent mental health services (CAMHS) in order to improve access to these services for children and young people with learning difficulties and/or disabilities and those who are in the criminal justice system.

Government, agencies providing services to children and young people and relevant inspectorates

- All government departments, agencies and relevant inspectorates should specifically include the impact of domestic violence on children and young people within their risk assessments for planning, delivering, evaluating or inspecting safeguarding services.

Safeguarding groups of vulnerable children

Local authorities

- Local authorities should make adequate provision of safe, sustainable and supported accommodation and stop the use of bed and breakfast accommodation for care leavers and young people both at risk of custodial remand or returning to communities from custodial settings.

Government

- The Department for Children, Schools and Families* and the Home Office should monitor at a national level the incidence of children missing from home.
- The Department for Children, Schools and Families and the Youth Justice Board* should provide guidance to staff working in custodial and residential settings on the behaviour management of children and young people. Such guidance should include a model behaviour management strategy and emphasise that restraint should only be used as a last resort and should not be used solely to gain compliance. The guidance should make clear that methods of restraint should not rely on pain compliance.

* In instances where more than one government department has been identified as having responsibilities in regard to the recommendations, a suggested lead department has been named to liaise and coordinate this work.

- The Department for Children, Schools and Families and the Youth Justice Board* should issue a requirement that all incidences when restraint is used in custodial settings and which result in an injury to a young person are notified to, and monitored and publicly reported by, the Local Safeguarding Children Board.
- The Department for Children, Schools and Families and the Youth Justice Board* should issue a requirement that all incidents of strip-searching of young people in custodial settings are risk assessed and recorded and that this data should be monitored by prison safeguarding committees. The Youth Justice Board should monitor the aggregated data nationally across the secure estate.
- The Department for Children, Schools and Families and the Ministry of Justice*/Youth Justice Board should provide long-term funding for social work input into youth offending institutions.
- The Department for Children, Schools and Families, Department of Health* and the Youth Justice Board should make the necessary provision to ensure that all children who display, or are convicted of, sexually harmful behaviours are assessed and their needs for treatment are met.
- The Department for Children, Schools and Families, the Department of Health* and the Ministry of Justice/Youth Justice Board should ensure continuity in the provision of mainstream services, particularly health and education, when young people return from a secure setting into the community.
- The UK Border Agency should ensure that children are detained only in exceptional circumstances and for no more than a few days. The individual welfare needs of children should be taken into account, and that process documented, in any decision to detain and throughout the detention process.
- The Department for Children, Schools and Families should issue guidance to local councils to ensure that children whose detention continues for more than seven days are subject to an independent welfare assessment of their health, welfare, educational and developmental needs and have an individual care plan. The welfare assessment and care plan should inform weekly reviews of the continued detention of children.[7]

Child protection

Government and Local Safeguarding Children Boards

- The Department for Children, Schools and Families and Local Safeguarding Children Boards should ensure greater consistency in decision-making about when a serious case review should be commissioned.

Government and inspectorates

- Ofsted should report annually on the outcome of evaluations of serious case reviews.
- The Department for Children, Schools and Families should ensure that the national dissemination of biennial reports on the lessons learned is timely.

Government

- The Department for Children, Schools and Families and the Youth Justice Board* should ensure that the assessment tools used within the Youth Offending Service and secure settings are robust in addressing the safeguarding needs of children and young people.
- The Department for Children, Schools and Families, the Department of Health*, the Home Office and the Ministry of Justice should ensure that information-sharing arrangements between healthcare professionals and other professionals providing services for children are in place and monitored to ensure informed and coordinated service provision.
- The DCSF, supported by other relevant government departments, should provide an annual update of progress made on the recommendations in this report.

All agencies providing services to children and young people

- All agencies that have a statutory duty to cooperate (local authority children's services, district councils, police, primary care trusts (PCT), NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should clarify the chain of accountability and responsibilities for child protection from the front line through to their most senior level.

1 Chapter 1: The safeguarding framework

Introduction

1. The framework for safeguarding children has changed considerably since the second *Safeguarding children* (2005) report was published. The Every Child Matters: Change for Children programme is well established and promotes five major outcomes for children: being healthy; staying safe; enjoying and achieving; making a positive contribution; and achieving economic well-being. Joint inspections assess how well agencies work together to improve these outcomes. The provisions of the Children Act 2004 are now largely in force and are significantly changing the way children's services are delivered at local level. The National Service Framework for Children, Young People and Maternity Services (2004) is also promoting greater recognition of safeguarding children in the NHS.

2. The key features of the current safeguarding children framework are:

- the duty to cooperate to improve the well-being of children and young people
- the duty for the key agencies that work with children to make arrangements to safeguard and promote the welfare of children and young people
- the replacement of non-statutory area child protection committees with Local Safeguarding Children Boards (LSCBs) to coordinate and monitor safeguarding at a strategic level in local areas
- the appointment of local directors of children's services and the establishment of multi-agency children's trusts
- the development of a children and young people's plan in every area, with at least annual evaluation by partner organisations
- the planned introduction of a new scheme for vetting people whose jobs bring them into contact with children.

3. This chapter considers to what extent all aspects of this framework are in place, what effect it has had on outcomes for children and young people and what improvements are still needed. It also considers other aspects of safeguarding arrangements that have an impact on children and young people, including multi-agency public protection arrangements.

Local Safeguarding Children Boards

4. The Children Act 2004 established LSCBs as a statutory requirement. They replaced the former area child protection committees, which were non-statutory bodies, on 1 April 2006. LSCBs are the principal mechanism in each of the 150 local authority areas in England for agreeing how the relevant agencies will work together to safeguard and promote the welfare of children. LSCBs' primary functions are:

> 'To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established. To ensure the effectiveness of what is done by each such person or body for those purposes.'[8]

5. The statutory guidance in *Working together to safeguard children* explains that the LSCB's role includes: carrying out responsive work to protect particular children and young people; being proactive in working for children in need and vulnerable groups; and promoting the safety and welfare of all children and young people living in their area.[9] The guidance indicates that LSCBs have a specific focus on the staying safe outcome, but children's trusts have the wider responsibility for planning and delivering services. LSCBs contribute to commissioning and delivery through the children and young people's plan and the children's trust. Local areas have flexibility to extend the functions of their LSCB provided that this does not reduce the LSCB's ability to perform its core functions effectively. The guidance also states that LSCBs should focus initially on their responsive child protection work if they judge it to be in need of improvement.

6. As part of the targeted inspection work for this review, Ofsted carried out a survey of LSCBs.[10] This followed up the (then) Department for Education and Skills' (DfES) own national survey of the progress made by LSCBs in 2006.[11] The findings of the Ofsted survey are based on 118 questionnaire responses and 19 structured interviews with LSCB chairs.[12] This section also draws on evidence from other inspection work and a Healthcare Commission audit of LSCBs.[13]

Structure, membership and participation

7. The 2007 survey shows that LSCBs are appointing more independent chairpersons (34% of LSCBs surveyed) and fewer directors of children's services as chairpersons, although the latter remains the most common

arrangement (40%) (figure 1). While this demonstrates a greater element of independence, there remains a heavy reliance on local authorities for chairing **LSCBs**.

Figure 1: Findings of surveys conducted in 2006 (DfES) and 2007 (Ofsted)

Chairperson	2006	2007
Directors of Children's Services	48%	40%
Independent	17%	34%
Other local authority officer	34%	33%
Other statutory partners	1%	3%

Sources: DfES 2006 and Ofsted 2007.

8. This is important in enhancing LSCBs' independence and capacity to influence local safeguarding arrangements. Local councillors, especially lead members, are better informed about the LSCB and safeguarding issues in their area. There are examples of robust and regular overview of LSCBs' work, which enables councillors to hold their local agencies to account for the effectiveness of their work (see examples below). In other areas, contact between councillors and LSCBs is more informal and less regular.

Examples of the effective overview of LSCBs' work

In Stockport, quarterly safeguarding accountabilities meetings are held that include the chief executive, leader of council, executive councillor for children and young people, and the chairperson of the LSCB. The Director of Children's Services (LSCB chairperson) also meets weekly with executive councillors and safeguarding is a regular agenda item.

Telford and Wrekin and Sunderland LSCBs collaborate to carry out peer reviews of their respective performance.

9. The survey results show that problems persist in a few areas in securing regular or consistent attendance at a sufficiently senior level from all member agencies with a duty to cooperate.[14] This has partly arisen from organisational changes and the restructuring of certain local services. All the LSCBs that responded to the 2007 survey had secured membership from the local authority, district councils where appropriate, probation, police and PCT. Probation inspections show that the local probation board was always part of, and often a full and effective partner in, the LSCB. However, eight LSCBs have no representation from Connexions; three have no representation from Cafcass;[15] and nine have no Youth Offending Service representation.

10. The Healthcare Commission audit of LSCBs shows that there has been an increase in NHS trust membership and in the seniority of trust representatives compared with the former Area Child Protection Committees. The Ofsted survey found representation from prisons and secure training centres on 26 LSCBs, covering nearly all areas where these establishments exist. LSCBs perceived their contribution to be reasonably effective. However, it is questionable whether the seniority of representatives from some youth offender institutions is sufficient to raise the profile within LSCBs of safeguarding children in these establishments.

11. Representation on and participation in LSCBs by partners that are not named in the Act as Board partners varies considerably. The survey found that more than 90% of LSCBs have representation from voluntary and community services. However, the participation of education establishments was found to be particularly variable, with state schools being represented on 89%, independent schools on 18% and further education (FE) colleges on 42%. The CPS, which prosecutes people accused of an offence, encourages CPS Areas to work with LSCBs, but they were represented on only 19 LSCBs (16%). However, the majority of CPS Areas have engaged to some extent with LSCBs, although contact varies considerably from attendance at the meetings, or links via other agencies or meetings, to the provision of named points of contact only. The armed forces are represented in 19 areas where there is a significant concentration of services. Chairpersons consistently described their contribution as being focused on operational rather than strategic issues.

12. Like the DfES survey in 2006, the 2007 Ofsted survey also found that the levels of resources available to LSCBs varied substantially. Nearly all LSCBs noted concerns about securing sufficient financial resources and staffing to carry out the range of work planned. However, since the survey was completed, the Department for Children, Schools and Families (DCSF) and Department of Health (DH) have announced additional funding for local authorities and the health service to cover the cost of child death review processes. The survey also found wide and unexplained variations in the funding contributions of partner agencies

between LSCBs. For example, the organisation of the police service means that several LSCBs have membership and financial contribution from the same police force. However, variations in financial contributions provided by the same force to different LSCBs do not appear to be based on clear assessments of the needs of children and young people in these areas. Overall, local authorities, PCTs and police services provide the largest percentage of financial contributions to LSCBs.

Priorities

13. Since the DfES survey in 2006, nearly all LSCBs have started to be involved in a wider range of safeguarding activities, instead of focusing largely on child protection. One in four LSCBs which responded to the survey identified raising awareness of the wider safeguarding agenda between agencies and improving arrangements to combat bullying as high priorities (figure 2). Nonetheless, the majority of LSCBs continue to be concerned principally with operational and procedural arrangements for safe workforce practice and child protection and with implementing national guidance and standards. In this respect, LSCBs are making good progress on setting up child death overview arrangements. All but one expected to have child death review panels in place by the deadline of April 2008.

Figure 2: LSCBs' local priorities

	Priority	Frequency
1	Establish a safe workforce practice	47%
2	Maintain an effective child protection service	31%
3	Establish a child death review panel	28%
4	Raise awareness of the wider safeguarding agenda	26%
5	Establish quality assurance and performance monitoring	26%
6	Increase the effectiveness of LSCB	25%
7	Reduce the incidence of bullying	23%
8	Reduce the incidence of domestic violence	20%
9	Deliver training programme	18%
10	Review multi-agency safeguarding procedures	15%

Source: Ofsted, LSCB survey 2007.

14. One in five LSCBs identified reducing the incidence of domestic violence as a priority. However, there is little demonstrable evidence of LSCB impact in this area, either through direct work or through partnerships such as domestic violence forums and multi-agency risk assessment conferences (MARAC). Some areas report that arrangements for identifying and notifying incidents and providing victim support services are improving. However, few LSCBs have developed measures to monitor the incidence and timeliness of support to children who witness or experience domestic violence. Nearly all areas face challenges in developing adequate provision for working with perpetrators and in providing emotional and psychological support for children who experience domestic violence.

15. Despite the emphasis on safeguarding vulnerable groups in the guidance to LSCBs, fewer than one in 10 have given high priority to targeted activities to safeguard specific vulnerable groups. These include: looked after children; those in private fostering arrangements; asylum-seeking children in the community and in short-term holding centres and immigration removal centres; children in mental health settings; and those in secure settings, especially when placed outside their area. In addition, while nearly all LSCBs are working with their local Crime Reduction and Disorder Partnership to coordinate safeguarding arrangements for children and young people (see paragraph 89), most are at an early stage of developing strategies or practice guidance to respond to locally identified issues such as gang or violent street culture.

Impact

16. The 2007 survey found that LSCBs' processes for measuring their impact are still at an early stage of development. Very few LSCBs have set themselves measurable success criteria or targets that are distinct from national or key performance indicators. Most are dependent on local authority children's services data, which provides limited information on the wider safeguarding agenda. Most LSCBs also acknowledge that they need to consult more regularly with children and young people to ensure that policy and service delivery reflect their views wherever possible. Where consultation has taken place, LSCBs have subsequently given greater emphasis in their priorities to the concerns of children and young people on issues such as bullying and community safety.

17. In terms of learning the lessons from practice, there is unacceptably wide variation in both the frequency and effectiveness of serious case reviews. One in four LSCBs has not yet carried out a serious case review while five have carried out five or more. This is not wholly consistent with the number of serious incidents or deaths of children between areas. This is considered in more detail in the section on serious case reviews in Chapter 4.

The duty to cooperate: strategic partnership working

18. Good partnership working between all the relevant agencies is a precondition for safeguarding children and for ensuring that their needs are recognised and met. The Children Act 2004 recognised this principle by establishing a statutory duty to cooperate to promote the well-being of children.

19. Strategic partnerships to safeguard and promote the welfare of children and young people have been established in all areas through the Children and Young People's Strategic Partnerships (CYPSP) and subsequently through children's trusts.[16] All areas have produced children and young people's plans and are reviewing them at least annually.[17] The plans are underpinned by strong adherence to the principles of Every Child Matters and a clear focus on each of its five outcome areas. In nearly all areas, these are leading to more effective targeting and better coordinated service provision for children and young people

20. However, some LSCB chairpersons expressed concern that the roles and responsibilities of the children's trust, strategic partnerships and LSCBs in determining safeguarding policy and procedure had become less clear. LSCBs have a key role in the strategic coordination of safeguarding activity, yet some found that this responsibility duplicated that of the local CYPSP and the children's trust.

21. Children's trusts are now established in all areas. However, the quality of partner relationships and the extent of different agencies' involvement have been inconsistent between areas. Government guidance indicates that each area should determine its own arrangements. Unsurprisingly, there are therefore considerable variations in organisational structures and functions. Some are fully integrated children's services trusts while others exist solely for commissioning. Nearly all are at too early a stage to make judgements about their effectiveness.

22. Cooperation across agencies is generally good, with many examples of involvement of the voluntary sector and community and faith groups. There is less involvement of the private and independent sectors. Many services, such as the police, health services, education and social care services, have long experience of making links with other agencies and working together at operational level to safeguard children. There are also examples of a good approach to partnership working by individual agencies.

23. At a strategic level, the introduction in June 2006 of the 'Children and Young People: CPS policy on prosecuting criminal cases involving children and young people as victims and witnesses' and in April 2008 the violence against women strategy, support the CPS in fulfilling one of the main features of its role in safeguarding – that of safeguarding children as victims and witnesses. It also supports the partnership approach. CPS community engagement strategy is now more tailored to secure benefits in service delivery. At a local level, this is reflected by involvement with domestic violence forums, support groups for victims and witnesses, and schools, for example as part of the school citizenship programme.

24. There is greater integration of services particularly between health and children's services. Examples include jointly provided services for children with learning difficulties and/or disabilities and children's centres. Most areas are developing joint commissioning arrangements for services for all children in need through their children's trust. However, most areas have established joint commissioning and effective contract monitoring arrangements for placements for looked after children. Access for children and young people and their families to preventive services that address different levels of need is increasing through commissioned provision from a wide range of statutory, voluntary and independent agencies.

25. However, the development of services through joint working, especially preventive services, is inhibited by the wide range of funding streams and the fact that much funding is time-limited. Two examples illustrate this. First, social worker posts were established in prisons where children are held in 2005. Their remit was to promote the welfare of children in custody and to make links

with relevant local authorities concerning the welfare of looked after children and care leavers. Initial funding was provided for a year. Each year since then there has been a debate about who should fund the posts and funding has been provided only on a 12-month basis. The potential for developing these posts, which had started to achieve positive results, has therefore been constrained. Second, youth inclusion programmes, established in 2000, aimed to divert children aged eight to 17 from involvement in crime or anti-social behaviour and from entering the criminal justice system. The programmes focus on learning new skills, taking part in activities with others and getting help with education and careers. An independent evaluation of the first three years commissioned by the YJB showed that the programmes were having a positive impact on reducing offending. However, uncertainties about funding have caused gaps in service provision and restricted its continued development.

26. Inspections also highlighted common areas where improvement in strategic partnership working is needed:

- more widespread information-sharing and better use of data to identify gaps in service provision and poor performance
- the need to ensure that joint services are planned and provided across the full range of vulnerable groups of children.

Multi-agency public protection arrangements

27. MAPPA were introduced to assess and manage the behaviour of sexual and violent offenders.[18] To be managed under MAPPA, offenders must have been convicted of or cautioned for a relevant offence.[19] The legislation requires the police, prison and probation services to act jointly as the 'Responsible Authority' in each of the 42 local Criminal Justice Board (CJB) areas of England and Wales. It also requires a range of agencies and organisations to cooperate with the Responsible Authority in the assessment and management of risk. These include health, local authorities with housing, education and social services responsibilities, YOTs, Jobcentre Plus and electronic monitoring services, which monitor convicted offenders. Some CPS areas are also involved with MAPPA.

28. In addition, the Responsible Authority is required to keep the MAPPA under review and make any necessary changes. Each MAPPA area has a strategic management board to carry out the MAPPA's reviewing and monitoring functions. The MAPPA guidance strongly recommends that strategic management boards include representatives from bodies with a key duty to cooperate. It also recommends that representatives should have sufficient seniority to contribute to developing and maintaining strong and effective inter-agency public protection procedures and protocols on behalf of their agency.

29. Joint area reviews (JARs) found effective operational arrangements between MAPPA and children's social care services for identifying and protecting children and young people who may be exposed to risk by the release of an offender into the community. In some areas joint working at a strategic level was less apparent. Although LSCBs are generally represented on MAPPA strategic management boards, the role of the LSCB in monitoring the impact of MAPPA on outcomes for children and young people and the coordination of children protection processes with offender management programmes in the area is not always evident or well-understood.

30. The police are well-engaged and meeting their statutory responsibilities under MAPPA. Between 2002–03 and 2005–06 there was a 39% increase in number of category 1 registered sexual offenders.[20] This significant and rapid increase in demand resulted in workload and capacity problems for the service. Recent programmed inspections found that forces had taken action to tackle this through comprehensive staffing reviews and increases in staffing levels. Nonetheless, forces need to develop a sophisticated understanding of demand that goes beyond caseload and build the capacity and capability to respond proactively to future challenges and demands in this area.

31. Probation services are fully involved with MAPPA, but there is a lack of clarity about the role, function and responsibilities of YOTs in these arrangements. Not all YOTs were linked into the MAPPA strategic management boards. In addition, case managers were often unclear about how the system worked, how to refer cases to it and what their responsibilities were for ensuring effective assessment and communication. As a consequence, numerous cases were recorded by YOTs in MAPPA category 1 without being referred to the MAPPA Panel for consideration.

32. Arrangements in prisons for the overall management of young people who are subject to MAPPA while they are in custody are generally efficient and well-managed. These young people are often a risk to themselves as well as to others. Young people convicted of certain offences are vulnerable to bullying and victimisation and the nature of the offence may indicate that they have experienced child abuse, while difficulties coping with the length of their sentence can put them at risk of self-harm. However, MAPPA is not regarded as an integral part of safeguarding arrangements or included as part of the remit of the safeguarding committee in all youth offender institutions. Also, attendance at MAPPA reviews in the community by prison staff varies and is often affected by the distance from the prison and staffing capacity. Attendance by representatives from the smaller girls' units, which have higher staffing levels and fewer cases, tends to be more regular.

Safe recruitment and vetting

> **'Recognise that staff and carers are important in children's lives. People working with children and young people must be the right people, properly recruited and checked.'**
>
> **'Where appropriate, involve children and young people in choosing staff and carers.'[21]**

33. The second *Safeguarding children* (2005) report raised concerns about vetting practices both during staff recruitment and for staff who have been in post for some time. Following the *Bichard Inquiry Report*, the Government is introducing a new scheme for vetting people whose activities bring them into contact with children and vulnerable adults.[22,23] The revised scheme is more robust, particularly with regard to barring unsuitable adults from working with children. Its implementation is expected to be phased in from autumn 2008. Its key aims are:

- to provide employers with a more effective and streamlined vetting service for potential employees
- to bar unsuitable adults from working, or seeking to work, with children and vulnerable adults at the earliest opportunity.

34. JARs judged recruitment vetting practices for centrally employed staff to be adequate or better in nearly all local authorities. There is now much greater awareness of the need for and importance of CRB checking. Checking for new recruits is well-established in children's services and robust arrangements exist for checking contract staff in nearly all local authority areas. However, weaknesses in recruitment practices remain in some services, for example in the timeliness of checks on people who apply for approval as adopters resulting in delays in decision-making by adoption panels. Inspectors of YOTs were also concerned to note a few cases where staff were inappropriately allowed to take up their duties before CRB clearance had come through. In addition, there were widespread concerns from inspections about the extent to which agencies had undertaken checks on staff who were in place before the CRB was established in 2002 and who have remained in the same post. Similar concerns arise about staff who had been CRB checked on appointment but who have not been re-checked after three years. While this is not mandatory, it is accepted good practice.

35. There is a high level of compliance in NHS trusts, as assessed by trusts themselves, with the core standard for ensuring that all appropriate initial employment checks are carried out. In 2006–07, 377 trusts were compliant, while only 10 did not comply and seven could not give sufficient assurance of compliance. Nonetheless, the Healthcare Commission believes there is still much to be done to improve checking of existing staff who have remained in the same post for some time or who move jobs within an organisation. In a survey of maternity services in 2008, 30 trusts out of 148 (20%) reported all staff having had a CRB check, and 36% reported having over 70% of staff checked. Fifteen trusts (10%) reported fewer than 30% of maternity staff having received CRB checks. Good practice is for all staff to be checked every three years, although this is not mandatory. Fewer than 7% of trusts reported over 80% of staff having been checked in the past three years. Thirteen per cent reported that fewer than 25% of staff underwent CRB checks in the last three years.

36. In the police service, officers in specific posts should be subject to internal checks over and above enhanced CRB and security checks. Five out of 43 forces needed to improve arrangements to ensure that these additional internal checks were routinely carried out for holders of specialist posts in the forces' Child Abuse Investigation Units.

37. For secure settings, inspections found that vetting

procedures in three of the four secure training centres were robust but were inconsistently applied by the fourth centre. While all inspected youth offender institutions were checking new staff, the HM Prison Service (HMPS) did not require the checking of existing staff and only one establishment was carrying out retrospective checks. Only six out of the 14 establishments had 90% or more of their staff CRB cleared for working with young people. Three establishments only had around half of their staff CRB cleared. This is of particular concern in closed institutions where staff who may not have been vetted are permitted to carry out procedures such as strip-searching and restraint on vulnerable children and young people. In youth offender institutions, where there is a mixed population of children under the age of 18 and young adults aged between 18 and 21 who are managed on separate sites, staff who usually work with young adults and who are not required to undergo vetting procedures are sometimes cross-deployed to work with children.

38.The UK Border Agency has five short-term holding facilities at Heathrow airport. These account for a significant proportion of short-term immigration detention. One removals holding room mainly holds those being removed after they have spent some time in the UK. The remaining four facilities largely cater for those who have just arrived and are being questioned or have been refused entry (see paragraph 230). Staff are often dealing with very vulnerable unaccompanied minors and distressed children with their families. Detainees are regularly held there for more than 18 hours, and inspection evidence highlighted the case of a child who had been detained for 24 hours. All custody staff had undergone at least standard CRB checks. All those employed since a new contract was agreed had been cleared to the enhanced level and retrospective checking was being carried out on remaining staff. About a third of staff were yet to be cleared to the higher level.

Conclusions

39. **LSCBs** are in place with more independent chairpersons and better reporting arrangements than when they were first established in 2006. They are beginning to focus on a wider safeguarding role in addition to child protection. A survey carried out in 2007 shows the following:

- Some statutory partners are not yet involved in the work of LSCBs in all areas; these include Connexions services, Cafcass and the Youth Offending Service.
- Few LSCBs are giving high priority to targeted activities to safeguard specific vulnerable groups; these include looked after children, those in private fostering arrangements, asylum-seeking children in the community and in short-term holding centres and immigration removal centres, children in mental health settings, and those in secure settings, especially when placed outside their area.
- LSCBs are not yet in a position to demonstrate the impact of their work, since few have set themselves measures of their impact on safeguarding.

40. **Strategic partnerships** for delivering services to safeguard and promote the welfare of children are established in all areas. Agencies work together better to safeguard children than they did in 2005. Every Child Matters is providing a cohesive framework for joint working. There are several areas for improvement:

- Joint commissioning of services for all children in need is under-developed.
- The time-limited nature of some funding arrangements constrains the development of joint services. Examples include social worker posts in prisons and youth inclusion programmes, which have achieved positive results.
- The extent to which relevant agencies work together to safeguard children and young people through local MAPPA to manage the risks posed by sexual and violent offenders varies. For example, MAPPA are not represented on all LSCBs; there is a lack of clarity about the role, function and responsibilities of YOTs in MAPPA; and prison staff attendance at MAPPA reviews in the community varies.

41. There is now much greater awareness of the need for and importance of **CRB checking** for staff whose jobs bring them into contact with children. Agencies comply well overall with requirements for CRB checking for new recruits. However, there are continuing concerns about:

- the extent to which checks are carried out or updated on staff who have been in post since before the requirement for CRB checks was established in 2002; this particularly applies to staff in NHS trusts and youth offender institutions
- re-checking of staff who have been CRB checked on appointment but who have not been re-checked after three years, which is accepted good practice.

Recommendations

All agencies

- All agencies that have a statutory duty to cooperate on safeguarding children (local authorities, district councils, police, PCTs, NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should ensure that they are fully compliant in respect of statutory membership of LSCBs by 1 September 2008.[24]

Government

- The DCSF, the Home Office and the Ministry of Justice should clarify the roles, functions and responsibilities of agencies contributing to multi-agency public protection arrangements (MAPPA) and ensure that relevant agencies meet them fully.

Local Safeguarding Children Boards

- LSCBs should ensure that robust quality assurance processes are in place to monitor compliance by relevant agencies within their area with requirements to support safe recruitment practices. These processes should include regular audits of vetting practice and random sampling of compliance with CRB checks.

2 Chapter 2: The wider safeguarding role of public services

Introduction

42. The second *Safeguarding children* (2005) report found that the priority given to safeguarding children across local government, health services and the justice system had increased since the previous report in 2002. Nonetheless, it still varied considerably between agencies that are involved with children. This was especially so for agencies in the justice system.

43. Since 2005 the national framework for children's services has changed significantly with the progressive implementation of measures introduced by the Children Act 2004 and related legislation. The Children Act 2004 introduced a statutory duty for a wide range of public services to safeguard children and promote their welfare.[25] It requires agencies that come into contact with children to recognise that their needs are not the same as those of adults.

44. The Every Child Matters programme focuses on five key outcomes for children and promotes a shared commitment across agencies to achieving them. The National Service Framework for Children, Young People and Maternity Services, published in September 2004, is an integral part of Every Child Matters and aims at sustained improvement in children's health over a 10-year period. It is supported by a set of national indicators for children's services which inform the JARs and the annual performance assessment (APA) of councils' contribution to improving outcomes for children and young people. In addition, in November 2007, the Government announced a new Public Service Agreement to improve children and young people's safety. All these changes have rightly served to raise the expectations placed on agencies that provide services for children.

45. Safeguarding children goes much wider than simply protecting them from neglect and abuse, as Every Child Matters and the *Staying safe: action plan* emphasise.[26] It is also about keeping them safe from accidents, crime and bullying and actively promoting their welfare in a healthy and safe environment. This chapter considers how agencies interpret and carry out their wider safeguarding role in different settings and services. Where possible it also looks at how children themselves regard the success of efforts to safeguard them. Evidence in this chapter is based on the findings of a wide range of inspection activity. It also refers to work carried out by the office of the Children's Commissioner, 11 Million, and other published material.

Prioritising safeguarding

46. There is evidence of a strong commitment by agencies to extend their focus from child protection to a wider view of safeguarding. JARs have found that there is a clear focus on each of the five Every Child Matters outcomes. There is evidence that Every Child Matters is providing a shared and well-understood framework that underpins joint working between staff of different agencies.

47. All local authority areas have moved to an integrated council service for children and young people. Many of these organisations are at an advanced stage of development at senior management levels. In these local authority areas, well-planned structures enable staff to work across different services to provide comprehensive care, especially to vulnerable children. For example, YOTs are increasingly becoming part of children and young people's services, having been early examples of service integration. In a few other areas, integration has not yet extended beyond senior management level or made a difference to front-line practice.

48. JARs have found that children's centres and extended schools are helping to promote good joint working. They provide a wide range of early intervention and preventive services which children, young people and their parents and carers value highly. Examples of such services include parenting programmes for parents and carers who have significant difficulties in maintaining positive relationships with their children.

> *Example of innovative safeguarding work*
>
> The Ipswich Family Support Service provides flexible, needs-led support for children and young people with emerging emotional and behavioural difficulties, in partnership with a voluntary trust. An evaluation of the service shows this is effective in reducing school exclusions and preventing mental health problems by early intervention.

49. Inspections have found that most schools have effective structures for supporting vulnerable children. Well-developed strategies and effective provision help vulnerable children to cope with transitions and major life changes. These include the transition from primary to secondary school, peer mentoring, targeted support, for

example for Traveller children and young carers, and rapid response services to support children and young people in coping with traumatic events such as the death of a parent or relative.

50. In the NHS, the attention given to safeguarding children is increasing. NHS trusts have worked hard to raise the priority of children's issues. Most trusts (in 2006–07, 377 out of 394 – 95%) comply with the core standard for safeguarding children and young people monitored by the Healthcare Commission.[27] Nearly all trusts have made progress in providing child-friendly environments, appropriate security and play areas. However, concerns remain about the priority given to children's issues by some trust boards and independent providers, which reflect the findings in the second *Safeguarding children* (2005) report. The Healthcare Commission has also raised concerns about levels of basic child protection training, lack of training of staff in communication with children and the maintenance of skills by surgeons who operate on children.[28] The Confidential Enquiry into Maternal and Child Health has also identified cases where healthcare practitioners had difficulty recognising serious illness in children owing to insufficient supervision or training in paediatrics.[29] These issues are considered in more detail in the section entitled 'Children using health services' in Chapter 3.

51. Despite the evidence of progress towards a wider view of safeguarding, a shared understanding of what safeguarding means in practice has not yet been established between all agencies. This is particularly apparent in the different approaches to children and young people's welfare applied by social care services and parts of the criminal justice system. Since the previous *Safeguarding children* (2005) report there have been improvements in the approach to safeguarding in secure establishments (youth offender institutions and secure training centres). These developments are noted throughout this report and described in detail in Chapter 3. However, progress is undermined by the application of stringent security measures that are based on the containment of adult prisoners rather than on an approach that assesses risk, acknowledges the vulnerability of children and properly balances security with their welfare needs.

Providing a healthy and safe environment

52. Feeling safe in their environment is one of the things children rank as being most important to them. In the TellUs2 (2007) survey, 95% of children said they felt very or quite safe at home and 85% did so when going to, and in, school.[30] This drops to 74% who felt very or quite safe around their local area and 68% on local transport. Much of the work of the Children's Rights Director, based within Ofsted, focuses on how safe children feel in different settings. In a recent report, covering a small but important targeted survey of children in need, when asked what would make children and young people feel safer, the top three replies were: harsher prison sentences for dangerous people (17%); children staying with someone they feel safe with (15%); and, alarmingly, carrying weapons such as guns or knives (11%).[31]

Regulated services

53. Foster care is the most common type of placement for looked after children and young people, with 42,300 children living with foster carers at 31 March 2007; 5,100 children were living in children's homes regulated by Ofsted. There was considerable year-on-year improvement between 2003 and 2007 in the proportion of these settings meeting the national minimum standards (NMS).[32] However, inspection and other regulatory work carried out between April and December 2007 shows that 7% of independent and 10% of local authority fostering agencies were judged to be inadequate in relation to staying safe. There were similar concerns about children's homes. Although 61% of all inspections conducted within the same period judged provision for helping children to stay safe as good or better, 29% were judged to be adequate and 10% inadequate. The most common failings identified were in the level of compliance with health and safety regulations, adequacy of staffing and the management and administration of medication.

54. In childcare provision, regulatory inspections found that around three fifths (61%) of the 27,000 early years providers deliver care of good or outstanding quality. A similar proportion of settings are judged good or outstanding in helping children to stay safe (59%) and to be healthy (63%). Around 800 providers (3%) were considered to be inadequate in supporting children to stay safe, which is an improvement on the 10% in 2004–05 that were required to take actions to improve

safety. Providers also improved in their compliance with standards for health, food and drink, first aid and hygiene. Where care was judged inadequate, there were a variety of reasons, many of them related to knowledge and understanding of safeguarding procedures, staff training on child protection and supervision of staff.

Maintained schools

55. Ofsted inspections of maintained schools include reporting whether schools meet current government requirements for safeguarding learners and how effective they are in providing for the care, guidance and support of young people. However, only a limited amount of detail can be included because of the wide range of other judgements that need to be reported. These inspections always investigate safeguarding work, but it is not always reported unless it does not meet government requirements or there are particular examples of good practice. Some issues, such as the school's joint working with agencies like children's services and its participation in inter-agency child protection processes, receive less coverage. Inspectors always check that schools have a central record of the vetting they have undertaken of staff and others who come into regular contact with children and young people through school activities. More than 99% of schools comply with this requirement.

56. There are a number of other judgements in school inspections that are directly relevant to safeguarding. They are grouped under the headings of 'Personal development and well-being' and 'Care, guidance and support'. The majority of schools (70% or more for each individual judgement) are rated good or outstanding in these areas but attendance is notably weaker. Very few (5% or less) are judged to be inadequate. Less than 1% of primary schools and 3% of secondary schools are judged inadequate for behaviour. These findings suggest that the great majority of maintained schools are orderly places where standards of behaviour fall within acceptable boundaries in terms of avoiding overt danger to others. Similarly, pupils largely demonstrate proper respect and concern for each other's feelings. Most schools also provide good individual care and support for vulnerable pupils. School inspections do not generally inspect bullying and harassment in depth. However, if inspectors have concerns they will follow them up in more detail. Most inspections judge that, at the minimum, pupils have confidence that such concerns will receive an appropriate response from staff. Nevertheless, when asked directly about how well their school deals with bullying a third of the children and young people who responded to the TellUs2 (2007) survey were less positive about the way schools dealt with such incidents. Parents are positive about standards of behaviour at their children's schools.

Independent schools

57. Ofsted inspects about half of the independent schools in England, which span a broad spectrum of faith and private schools. Around a third of these schools cater wholly or mainly for pupils with learning difficulties and/or disabilities or who are in public care. All independent schools are inspected in accordance with the standards for independent schools, which are set out in the Statutory Instrument.[33] The core inspection purpose is to check that the school's provision meets these standards within the context of the needs of its pupils. In inspecting the school's provision for welfare, health and safety, inspectors take particular account of measures to counter bullying and safeguard children through safe recruitment, and the promotion of good pupil behaviour more generally. Just under 60% of the independent schools inspected by Ofsted are judged to offer good or outstanding provision for pupils' welfare, health and safety, with around 12% inadequate.

58. A significant minority of schools are found to be non-compliant with some aspects of the regulations relating to the suitability of proprietors and staff for working with children and young people at the time of inspection and to written policies to safeguard and promote the welfare of pupils. Judgements on the suitability of premises, however, are generally much more positive. Where schools do not meet regulations, they are required by the DCSF to submit for approval an action plan stating how and when they will address the regulations they have not met. Moreover, the DCSF may request that Ofsted conducts a further inspection of the school.

59. The Independent Schools Inspectorate (ISI) inspects schools that are members of the Independent Schools Council, and the Schools Inspection Service (SIS) inspects a small number of Brethren schools affiliated to the Focus Learning Trust. Very few schools are within the SIS remit so no clear conclusions can be drawn, although the inspection procedures are the same as for ISI and both are monitored by Ofsted; one SIS school was inadequate in meeting requirements in 2007–08. Ofsted, SIS and ISI

inspection reports identify any areas where schools fail to comply with regulations and highlight areas where, though not in breach of regulations, there is room for improvement. The ISI also liaises with the DCSF about any concerns raised by parents or others. Where necessary, the ISI undertakes short or no-notice visits to schools at the request of the DCSF, especially where matters of child protection are concerned, although the DCSF retains the right to ask Ofsted to visit the school where serious concerns are raised. In 2006–07 94% of schools inspected by the ISI were graded good or outstanding in relation to the welfare, health and safety of pupils and none was graded unsatisfactory. On the occasions when schools have not met welfare and child protection requirements, the ISI reports that it has no recorded instances where schools have failed to improve their practices when directed to do so following instruction by the Registering Authority.

Further education

60. Ofsted inspects colleges and providers of work-based learning, apprenticeships, learndirect, adult and community learning, and education in accordance with the Safeguarding Vulnerable Groups Act 2006. It also inspects education provision in prisons at the request of Her Majesty's Chief Inspector of Prisons. All inspections require inspectors to make judgements in relation to safeguarding children and vulnerable adults. Inspectors grade the care, advice, guidance and other support provided to young people to safeguard their welfare, promote their personal development and help them achieve high standards. Of the 287 colleges graded from September 2005, 21% were considered outstanding, 57% good, 20% satisfactory and 2% inadequate for this aspect of their work. In learning and skills provision other than colleges of further education inspected from April 2007, 9% were considered as outstanding, 58% good, 31% satisfactory and 2% inadequate. This grade includes a judgement on the robustness of processes for safeguarding children and vulnerable adults.

Other local authority services

61. Health and safety aspects were judged to be good in the vast majority of the 30 local authority youth services inspected. Youth services comply well with regulations in relation to outdoor, sport and off-site activities. Risk assessments for everyday youth work activities are also carried out well.

62. Providing adequate housing for families remains a significant problem in some local authority areas, although there has been an overall reduction in length of stay in bed and breakfast accommodation for families with children and homelessness is decreasing.

Preventing accidents

63. Accidents cause the deaths of three children in every 100,000 each year. There are approximately two million attendances by children at accident and emergency departments as a result of accidents, many of which could have been prevented.[34] Overall, the death rate and the serious injury rate for children have fallen since 1995.[35] However, unintentional injuries, such as those caused by burns, falling downstairs at home and poisoning, remain a leading cause of death in children aged 1 to 14 and account for approximately 120,000 hospital admissions each year. There are persistent and widening differences between socio-economic groups. For children whose parents have never worked or who have been unemployed for a long time, the incidence of death from unintentional injury is 13 times higher than for children whose parents are in managerial and professional occupations.

64. The Audit Commission and Healthcare Commission's review found that local initiatives to help prevent accidents to children were often ad hoc and uncoordinated, relying on committed individuals working in isolation. The review identified effective partnership working as a key factor in preventing accidents (see next page), requiring sustained commitment and cooperation at a local level. Common characteristics of successful partnerships include coterminous local authority and PCT boundaries, strong leadership and project champions to drive and monitor progress. JARs have also found good multi-agency strategies, for example to promote road and fire safety. The national indicator set for children's services includes a measure for children who are seriously injured or killed in road accidents. This has shown a year on year reduction in serious injuries to and deaths of children in road accidents. The Government's objective for a 50% reduction by 2010 was met in 2006 when figures showed a 52% reduction against baseline.

Example of targeted work to reduce accidents to children under five

In Burnley, Pendle and Rossendale strong links between the PCT's accident prevention team and the A&E department resulted in targeted and successful campaigns to reduce accidents to, and hospital attendances by, under-fives. Measures included free installation of safety equipment in deprived areas. The overall estimated saving to the local economy was £1.9 million.

Secure settings

65. Three out of the four secure training centres where children and young people who offend are housed were found to offer satisfactory and safe accommodation. In one centre, cramped living areas are partly responsible for problems with behaviour and control, which are described in more detail in Chapter 3.

66. Inspections continue to raise concerns about standards of safety and comfort in prisons. In the most recent surveys of young people's views carried out as part of prison inspections, 29% of boys in the 13 youth offender institutions and two specialist units reported feeling unsafe at some point during their time in custody – a small improvement on the views expressed in the previous surveys.[36] Across the entire juvenile prisons estate, fewer boys (32% compared with 38% in the previous survey) said they had felt unsafe. Only 30% of girls reported having felt unsafe, compared with 63% in the previous survey period.

67. HM Inspectorate of Prisons has described the juvenile prisons estate as 'over-used, under-resourced and increasingly tired'. Reception facilities are frequently poorly maintained and not appropriately resourced to provide a welcoming and safe environment for new arrivals, particularly those who are experiencing their first time in custody. Inadequate staffing ratios in large, poorly designed residential units undermine efforts to provide a safe and healthy environment in a number of youth offender institutions that hold boys. Basic standards of care, such as opportunities to take a shower or eat meals communally rather than in cells, are often compromised simply because there are too many volatile young men (up to 60) in a single unit to be managed together safely. This also influences the amount of time young people are allowed out of their cells to associate with each other and make telephone calls to their families. One young man wrote in his survey questionnaire, 'We only have association once a week and due to that we don't get to know each other. I think that if we got to know people better there would be fewer fights.' Very few boys have access to scheduled time in the fresh air every day. In contrast, the newer and smaller girls' units provide much better accommodation, all meals are taken communally in a comfortable dining area and young women have good access to outside areas.

68. Inspection reports give examples of night staff in prisons who were not trained in emergency procedures, including fire procedures, and were not always equipped with necessary emergency equipment such as ligature shears (specially designed tools to cut through ligatures quickly and safely) to deal instantly with an emergency. It is now a mandatory requirement for staff to carry ligature shears.

Promoting health and well-being

69. Local authority areas are carrying out many initiatives to support parents in improving their children's well-being. Increasingly, partner agencies are working together to increase provision of preventative and earlier intervention services for all children up to 16. Sure Start Children's Centres support children from 0 to 5 years. They aim to improve outcomes for families and all young children, particularly in disadvantaged areas, by providing easy access to integrated early education and childcare, a range of family and parenting support, outreach and health services, information and advice and links to training and employment opportunities. Using trained peer supporters, some children's centres have contributed to an increase in breastfeeding and reductions in smoking during pregnancy. However, these initiatives have not yet made a significant impact on achieving national targets for breastfeeding and smoking cessation.

70. Access to health services, especially to GPs, health visitors and dentists, is limited in some areas. There is also a significant waiting list for speech and language services in most areas. A shortage of health visitors and school nurses has an impact on the promotion of health and well-being by reducing possibilities for early intervention. Action has been taken by some NHS trusts to address low numbers of specialist paediatric nurses in accident and emergency departments. For example,

seven day a week cover by nurses with experience in caring for children is increasing. A training and competency framework for the range of nursing staff working with children has also been developed by the Royal Colleges. However, there is evidence that some health services, including primary care and CAMHS, are failing to meet the National Service Framework recommendation to follow up on those children who miss clinical appointments. This is important in determining whether there are underlying reasons for non-attendance relating to parental neglect, mental health or other safeguarding factors.[37]

71. National Healthy Schools Status promotes healthy lifestyles for children and young people through a school-based national programme.[38] The number of schools participating in this initiative is increasing and many are linking healthy lifestyles to healthy eating and exercise plans. However, engagement in the programme varies: in some areas, only 50% of schools participate, while in others 85–97% participation has been reported. Most participating schools have wide-ranging programmes that link with other lifestyle initiatives, both within and outside the school. These include planning safe routes that encourage children to cycle or walk to school and fitness activities for pupils during lunch breaks. Pupil members of school councils are becoming increasingly involved in aspects of the programme, which are delivered with partners from health and social care services. Youth services are becoming increasingly involved and were judged in inspections to be making a good contribution to promoting young people's health and general well-being.

72. Children themselves have largely understood the concept and importance of leading a healthy lifestyle, but many have yet to adopt it in practice. From the TellUs2 (2007) survey, 86% said they are very or quite healthy, but only 23% say they eat five or more fruit and vegetables every day. Twenty-two per cent spent 30 minutes on exercise on less than one to two days during the previous week. This is despite the existence of schemes in local authorities to issue discounts for children and young people to access sports and other facilities. The development of multi-agency strategies to reduce obesity in children is at an early stage and existing strategies have yet to make a significant impact.

73. The lack of access to time in the fresh air for young people in youth offender institutions described above (paragraph 67) is inconsistent with examples of attempts to promote healthy lifestyles through good access to physical education (PE). Many PE departments in youth offender institutions have good links with education, substance misuse and healthcare departments and work jointly to develop healthy lifestyle programmes. PE departments often provide remedial classes for young people who are reluctant to take part in classes within the youth offender institution for a variety of reasons. Healthcare departments in youth offender institutions generally offer good health promotion and a range of nurse-led clinics, including sexual health clinics. Pre-release planning generally includes steps to encourage young people leaving prisons to lead a healthier lifestyle, for example arranging follow-up appointments and registration with GPs for young people who have none.

Reducing teenage pregnancy

74. The UK has the highest rate of teenage pregnancy in Western Europe. Research has shown that the physical health, emotional and mental health and economic outcomes for teenage parents and their children are generally poorer than those for older mothers. Surveys of young people in YOTs during inspections also showed that, where reasons were specifically given, a commonly cited reason for not complying with a criminal order was that the young person was pregnant or had a partner who was pregnant. Other reasons given included the difficulties of arranging childcare. Eleven per cent of young people surveyed in prisons reported that they had children.

75. The Government's Teenage Pregnancy Strategy aims to tackle both the causes and the consequences of teenage pregnancy. It contains two targets:

- to halve the under-18 conception rate by 2010 (from the baseline year of 1998) and establish a firm downward trend in the under-16 rate
- to increase the proportion of teenage parents in education, training or employment to 60% by 2010, to reduce their risk of long-term social exclusion.

Rates of teenage pregnancy are increasing in about 10% of areas. National targets will not be achieved at current rates of progress: the conception rate for girls aged under 18 years has declined by 13.3%, and for those aged under 16 years has declined by 13.0% since 1998, the baseline year for the Teenage Pregnancy Strategy.[39]

76. JARs and APAs show that multi-agency strategies in

most areas are well-targeted on areas of highest need (see examples below). Service provision for teenage mothers has also increased to involve them in education, employment or training. Sex education is now part of Healthy Schools Status, but its impact has been variable, and there are concerns in a few areas about the funding available to continue this work.

Examples of work to reduce teenage pregnancy

The APA 2007 noted that South Tyneside is recognised as an area of innovative practice by the *British Medical Journal* in terms of its work with teenage mothers to prevent repeat unintended conceptions. The conception rate for girls aged 15–17 reduced by 25.8% between 1998 and 2005.

In Stockport, the youth service is particularly effective in providing comprehensive sex and relationship support, advice, treatment and education. The service has been instrumental in contributing to the decreasing rates of teenage pregnancies, which reduced by 23.9% between 1998 and 2005 for girls aged 15–17.

Tackling substance misuse

77. Misuse of substances (including alcohol, drugs and solvents) by children is a factor contributing to behavioural and associated problems. In terms of drug misuse among children, 17% of children aged 11–15 had taken illicit drugs in the last year compared with 19% in 2005; 24.8% of young people aged 16–19 had taken drugs in the last year.[40] In the TellUs2 (2007) survey 80% of children in Years 8 and 10 (secondary school) told us they had never taken drugs, but this means that one in five may have done so. Nineteen per cent overall admitted to having been drunk at least once during the previous four weeks.

78. Children are at risk not only from their own misuse of substances but also from that of their parents and other adults. Substance misuse is often a factor in domestic violence and sexual abuse. Children who experience abuse and neglect because of parental substance misuse are likely to suffer long-term developmental problems and poor outcomes. There may be around 250,000 children of problematic drug users in the UK, while up to 1.3 million may live with a parent who misuses alcohol.[41]

The Government is planning to introduce a new drugs strategy, which will include a focus on children, and take action to reduce alcohol consumption by children.

79. As with so many issues, good preventive services coordinated between agencies are a critical element in tackling the problems. JARs found that effective joint commissioning and partnership arrangements have improved the substance misuse services available to young people. The number of young people being referred for treatment is increasing, with access to specialist assessment within 10 days being the norm in some areas. Admissions to hospital for young people who misuse substances are also decreasing in the majority of local authority areas. Owing to a lack of suitable community care, some areas continue to hospitalise more young people than the national average.

Example of work to tackle substance misuse

In Warrington an innovative approach has been taken to tackling substance misuse. A number of young people have been trained as peer educators to deliver drug awareness programmes. A small group has produced high-quality publicity materials that have been distributed widely across the borough. There is also good support for children and young people who have a parent and/or carer who misuse substances.

Following user surveys in Derbyshire, young people were found to have a greatly improved understanding of the impact of substance misuse.

Health services in Sheffield are training and supporting colleagues from other agencies involved with young people to identify and refer swiftly to the appropriate service for treatment.

80. Substance misuse is often a factor in offending behaviour by children and young people. Of more than 1,700 YOTs case files considered from July 2005 to February 2007, misuse of alcohol was a major factor in 35% and misuse of drugs in 39% of cases. Young people in YOTs should be screened for substance misuse within five days and receive an intervention within 10 days. YOT performance improved on both indicators between October/December 2005 and July/September 2007. While many YOTs have established links with their local drug and alcohol abuse services, these links vary in their quality and effectiveness. There are particular difficulties

at the point of transfer from or to the community, when the need for support is greatest.

'I have gained a lot more self confidence and I am back on track career wise as I am starting college in September. I have learnt what's right and wrong and that the amount of alcohol I used to drink in my last relationship was dangerous. I have stayed off alcohol for about five months now which I am proud of.' (Young person)

81. All youth offender institutions now have a dedicated substance misuse service and assessments are normally carried out within the five-day target for new arrivals. Programmes for low-level abusers are generally good and substance misuse strategies always include alcohol misuse. In addition, all youth offender institutions are non-smoking and there is reasonable support for smoking cessation. Support is not so well-developed for young people with higher levels of dependency who require detoxification. In addition, on release young people may fail to access mainstream substance misuse services in the community, since work carried out in custody is not always followed up in a timely way. This is often because access to rehabilitation and aftercare provision of substance misuse services is inconsistent across the country.

Improving CAMHS

82. The National Service Framework for Child, Young People and Maternity Services includes the mental health and psychological well-being of children and young people as one of its 11 standards. CAMHS are now delivered in line with a four-tier framework, in which practitioners, services, settings and responses are increasingly specialised according to the nature of the disorder. This is the commonly accepted basis for planning, commissioning and delivering CAMHS, although there are variations in the way the framework has developed across the country.

83. The previous *Safeguarding children* reports highlighted CAMHS as an area where there was considerable scope for improvement. Problems included: limited access to services; the low priority given to safeguarding within services; poor transitional arrangements to adult mental health services; and a lack of attention to the mental health needs of young people in the criminal justice system. A recent report commissioned by 11 Million raised substantial concerns about the treatment and experiences of young people with mental health problems on inpatient adult psychiatric wards.[42] The Government made a commitment in s13A of the Mental Health Act 2007 to ensure that, by April 2010, no patients under 18 are 'placed inappropriately', for example in adult wards when a more suitable environment is available. In response to 11 Million's report, the Government has also undertaken to bring to an end the inappropriate placement of all children aged 16 and under by November 2008. In the interim, since June 2007, protocols have been put in place to ensure that where children are placed on adult psychiatric awards, their needs are met and that they are transferred to an appropriate setting within 48 hours. In addition, the Government has commissioned a review of CAMHS to report in 2008 on how universal, mainstream and specialist support services can be improved for children and young people with mental health needs. The consultation for this review is under way.

84. JARs found improvements since 2005, but identified aspects where there are still weaknesses, despite considerable government investment. Most areas consider that they are making progress towards the development of CAMHS, but few have comprehensive coverage, which is the aim of the Government's Public Service Agreement target.[43] Provision for children and young people with learning difficulties and/or disabilities is slow to develop in most areas. This is considered in more detail in the section on children with learning difficulties and/or disabilities in Chapter 3. Service provision is increasingly age-appropriate, particularly at Tiers 1 and 2, and the establishment of children's centres has done much to promote mental and emotional health. They enable parents to benefit from initiatives such as postnatal depression support groups and to work with practitioners to improve bonding and communication with their children.

Example of excellent CAMHS provision

CAMHS provision in Kensington & Chelsea has been awarded beacon status. It is a flexible, accessible and well-coordinated service. Its chief impact has been through increasing capacity and thus facilitating early intervention and support. All services have increased awareness of the emotional needs of children and young people and can gain access to support, guidance and specialist support. There are good support services for parents with children who have emotional or mental health needs and close attention is paid to holistic assessments. Well-targeted services are also provided to children who present at A&E; interventions are timely and aimed at rapidly dealing with problems.

85. However, there is a shortage of suitable hospital beds for young people in some areas and timescales for access to Tier 3 services are improving but waiting times remain too long. There are still considerable weaknesses in transition arrangements for young people moving into adult services. This reflects the position in 2005. Providing services for children with learning difficulties and/or disabilities and with complex needs is particularly challenging. Agencies often find it difficult to identify all their many needs and determine the appropriate responses.

86. YOT inspections of 1,700 case files show that 41% of children and young people had emotional or mental health needs. For those in custody, this rose to 60%, while 14% of young people in custody were vulnerable to self-harm. Community mental health trained nurses are seconded to some YOTs while others have specific protocols for the provision of mental health services. Difficulties remain in transition between child and adult services. In prisons, mental health provision has improved considerably and is now generally good. Not all prisons holding children have access to CAMHS but most have visiting psychiatrists and other mental health specialists, although specialist counselling services are limited.

87. Nonetheless, prisons and secure training centres are still holding children with mental health problems whose needs should be catered for either in secure or semi-secure specialist provision. Access to secure mental health beds remains limited, particularly in the south where there are too few places to meet the demand. Good systems exist within prisons to identify need and make referrals, but there is frequently a delay in getting approval for funding to make assessments for transfers from youth offender institutions to mental health secure beds. This is mainly because mental health services are commissioned by the PCT, but individual children are often placed in a youth offender institution that is outside the boundary of their local authority and PCT. In one establishment young people had to wait several months for assessments. For example, one young man had been referred in January 2007 but was not seen and assessed until May 2007, while another who had been referred in April 2007 was still waiting to be assessed six weeks later.

Dealing with domestic violence

88. Domestic violence has a direct and indirect impact on the lives of children and young people, and the links between domestic violence and child protection are well-established.[44] Successful intervention depends largely on early identification of risk, but the degree of under-reporting of domestic violence is known to be high. Also, there is limited data available, locally or nationally, to determine the incidence of domestic violence. Data from inspections gives some indication of scale, but it is not comprehensive. The number of domestic violence cases prosecuted by the CPS has increased significantly between 2004–05 and 2007–08, from around 35,000 to almost 60,000. However, some of this apparent increase may be attributable to improved identification and recording of such cases. JARs found a perception of a high incidence of domestic violence in most local authority areas. Consequently, most children and young people's plans and one in five LSCBs have identified domestic violence as a priority for action. Probation inspections found that there was a background of domestic violence in 23% (1,500) of all the cases reviewed in 16 probation areas.

89. Joint working arrangements to combat domestic violence have been strengthened in most areas, particularly between local authorities, the police and health services. The voluntary sector also makes a significant contribution at both strategic and operational levels. A number of Responsible Authorities are required to work together to reduce crime and disorder.[45] Crime and Disorder Reduction Partnerships produce community safety strategies for each local authority area after conducting an audit of the local crime and disorder

problems, including domestic violence. Domestic abuse/violence forums have also been established with membership from a range of statutory and voluntary organisations, to assist in the delivery of crime and disorder targets. LSCBs are represented on Crime and Disorder Reduction Partnerships, and Ofsted's survey of LSCBs in 2007 showed that a fifth of those responding listed domestic violence as a high priority. However, most have yet to demonstrate the impact of such initiatives, particularly with regard to earlier intervention for children and young people who witness domestic violence.

90. Early intervention services are at an early stage of development but there are examples of good initiatives (see below). These include the development of resource packs for secondary schools that provide curriculum support in addressing domestic violence issues. All police forces have procedures to notify the local Child Abuse Investigation Unit (or equivalent) of incidents of domestic violence in households where children are present or normally resident. However, JARs found evidence of delays by the police in making referrals to children's services or by children's services in responding effectively, often arising from staffing capacity and workload issues. There is also a shortage of refuge accommodation for victims of domestic violence.

Examples of work to combat domestic violence

In Kingston upon Hull work with local magistrates to raise awareness of the impact of domestic violence on children has resulted in safer arrangements for children affected by separation and divorce.

Innovative schemes are in place in Hartlepool to tackle domestic violence, such as an outreach pilot between North Tees Women's Aid and the police, which is increasingly having a positive impact on numbers of women and children supported.

Hounslow has recently won an award for its Learning to Respect Scheme, which has helped over 2,000 school children explore issues relating to domestic violence and abusive relationships.

91. Individual agencies vary significantly in their approach to and knowledge and understanding of domestic violence. The police have a major role in identifying and responding to domestic violence (see example below) and the Association of Chief Police Officers (ACPO) first published comprehensive national guidance on investigating domestic violence in 2004. There is also a well-established national ACPO Steering Group and each force has an appointed domestic abuse 'champion'. Although domestic violence is the responsibility of every police officer, regardless of their role, all forces have specialist domestic abuse officers.[46] Traditionally, this role was primarily one of coordination and liaison, providing a single point of contact for victims and liaising with support agencies. Over the years the role has evolved, with specialist officers taking on a broader range of responsibilities. These include: monitoring attendance at incidents to ensure compliance with force policy; maintaining and updating records and databases; tracking cases through the court system to keep victims advised of progress; and risk assessment. As a result, these officers have faced considerable pressure in trying to balance a growing administrative commitment with the requirement to deliver an effective service to victims. More recently, in 21 out of 43 forces, the role has developed into an investigative one or the additional role of specialist domestic abuse investigator has been introduced. HM Inspectorate of Constabulary's programmed inspections in 2007 found that some forces were managing workforce and capacity issues relating to these changes better than others. The need to identify priority areas of demand and to build capacity has become a particularly critical issue for the service a a whole.

Example of a family safety unit set up by Merseyside Police

A review of Wirral Basic Command Unit in 2004 showed that it had a lack of provision for multi-agency intervention and support for victims of domestic abuse and for recording incidents. It set up a Family Safety Unit to provide a multi-agency single point of access to help victims to be safe and to coordinate responses. A manager, two caseworkers, two seconded police officers and an administrative support officer staff the unit. The local PCT seconded two midwives and a GP. Victims of domestic abuse receive a care package consisting of advice on the support and assistance available and immediate access to relevant services.

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A web-based inter-agency database alerts all agencies to high-risk cases requiring referral and immediate intervention. Local specialist domestic violence courts also ensure that victims receive a high quality service while cases are progressed through the criminal justice system.

In its first 16 months the unit supported more than 420 high-risk victims and the repeat victimisation rate for those using the service was very low at 6%.

92. All police forces have introduced formal domestic violence risk identification and assessment processes and some excellent and innovative work has been carried out in this area to improve both the protection of victims of domestic violence and investigations. Multi-agency risk assessment conferences (MARAC) were developed to help those at very high risk of domestic violence. Following risk assessment by specialist police domestic abuse investigators these cases are referred to a MARAC to develop a multi-agency response. MARAC has become established as a model of good practice after it was first pioneered in Cardiff in 2003. The Tackling Violence Action Plan, published in February 2008, committed the Government to rolling out MARACs nationally by 2010–11.

93. HM Inspectorate of Constabulary's programmed inspections of arrangements for protecting vulnerable people in 2007 found 31 police forces (79%) had introduced, or were introducing, MARACs. As this is still a developing area, coverage is often not comprehensive across all individual basic command units (BCUs) in the same force. The introduction of formal risk assessment and MARACs has had a significant impact on the role and workload of specialist domestic abuse officers. There has been a growing reliance on these officers to act as 'gatekeepers' in quality assuring the risk identification process and in carrying out the final risk assessment. This has increased their administrative burden, thus reducing their capacity to fulfil their operational role.

94. There is also a need to ensure that existing risk assessment processes in the police force are complementary to and aligned with those used within the MARAC model. No two forces use the same model or tool based on commonly understood risk factors and indicators. Since there is no national risk assessment model there is no associated national training. In some cases, therefore, inspections found that untrained officers were carrying out risk assessment. The recently revised Association of Chief Police Officers (ACPO) guidance emphasises the need to ensure that risk assessment is carried out only by trained officers. In addition, ACPO is developing core standards for domestic abuse risk identification, assessment and management in recognition of the need to ensure a more consistent approach nationally.

95. The Crown Prosecution Service (CPS) has a clear domestic violence policy that explicitly requires prosecutors to consider the safety of children and take into account the views of the victim. The CPS definition of domestic violence includes children as victims and perpetrators and therefore goes wider than the Government definition of domestic violence, which is the one adopted by the ACPO.[47] The CPS policy is supported by comprehensive training within the CPS Areas. A key theme is the consideration of children throughout the process. In addition, the CPS violence against women strategy, implemented from April 2008, draws together all the strands relating to violence against women, and includes child-related matters such as sexual exploitation and related categories of child abuse.

96. The Government's Specialist Domestic Violence Court programme has resulted in joint work at a strategic and local criminal justice agency level. In April 2008 there were 98 accredited courts that provide an enhanced level of service to victims of domestic violence. These courts have to meet 11 component requirements, which have become a national standard, one of which relates to children's support services.

97. Overall performance assessments of the CPS Areas show that processes are generally sound for ensuring that sensitive cases, including domestic violence cases, are dealt with by suitably experienced prosecutors at pre-charge decision stage. A number of CPS Areas have introduced specific charging clinics for rape and/or child abuse and/or serious sexual offences. Dedicated domestic violence specialists and rape specialists, and coordinators for both, are in post in CPS Areas. Owing to the volume of domestic violence cases, they are not exclusively dealt with by specialists. The majority of domestic violence

cases inspected as part of area effectiveness inspections were handled satisfactorily. The CPS domestic violence policy was applied correctly throughout the case in 94% of cases examined. Some shortcomings identified in individual cases included a failure to seek relevant background information, incorrect application of the domestic violence policy and a lack of timeliness in terms of preparedness. Late discontinuance of proceedings remained an issue, although some could be attributed to late withdrawal by the victims.

98. The National Probation Service (NPS) is committed to tackling domestic abuse and has over the last five years developed and rolled out across the 42 probation areas two accredited domestic abuse programmes (Integrated Domestic Abuse Programme and the Community Domestic Violence Programme). In 2005, the service introduced an Interim Domestic Abuse Policy and Strategy which raised the profile of this area of work, promoting a whole service approach. Integral to the accredited programmes has been the development of the Women Safety Workers who support the victims of domestic abuse while the perpetrator is attending an accredited programme. The National Offender Management Service (NOMS) is also undertaking detailed evaluation of the effectiveness of the programmes. This will evidence the degree of change in the men's attitudes as well as a comparison of the reconviction rates for men who complete the programmes.

99. Domestic violence was a feature in 18% of all cases seen in NPS inspections; in nine out of 10 cases, the offender was the main risk. However, the coordination of inter-agency responses to domestic abuse was not well-supported; three out of 10 cases did not demonstrate effective communication between probation and the police about subsequent call-outs. There were examples of outstanding individual practice in supporting victims. Inspections also noted delays in the delivery of the Integrated Domestic Abuse Programme and the use of the Spouse Assault Risk Assessment (SARA) tool.

100. In 2005, inspectors published a critical report about the way Cafcass and HM Courts Service dealt with cases involving domestic violence in family proceedings.[48] It reported findings that practitioners' understanding of domestic violence was insufficiently detailed and sometimes unacceptably poor. This posed risks to children and victims of domestic violence. Cafcass responded to the report by developing a comprehensive training programme and an excellent toolkit to guide practice in domestic violence cases. Cafcass is also a signatory to multi-agency guidance on commissioning services for children experiencing domestic violence. In addition, domestic violence is an integral part of the Cafcass safeguarding framework.

101. Despite these initiatives by Cafcass centrally, recent inspections of two Cafcass regions have found continuing unacceptable variation in front-line practice. In the East Midlands region, inspection found insufficient attention paid to domestic violence and service users expressed dissatisfaction with practitioners' performance in this regard. Inspection of the South East region found that the region's performance in this area was also inadequate. Domestic violence issues were alleged in 14 of the reports inspected, but its impact on children was assessed adequately in only three of those cases. In one case inspectors found serious mistakes and alerted the region, which took immediate action.

Preventing bullying, racism and harassment

102. Bullying and the fear of bullying are major preoccupations for many children and young people. In the TellUs2 (2007) survey, 25% of children said it was one of the things they worried about most. Children were more concerned about bullying in their local area, which is more difficult to deal with than in schools. However, while 70% said they had never been bullied, 5% (one in 20) said they had been bullied most days. Almost a third of respondents said incidents of bullying in schools were not dealt with well. JARs have also raised concerns about the bullying of children with learning difficulties and/or disabilities.

103. The Children's Rights Director has surveyed children's views on bullying.[49] His findings reflect many of those in the TellUs2 (2007) survey. In his survey, 41% of children thought bullying was getting 'a lot worse' while 23% thought it was getting 'a bit worse'. Electronic bullying increasingly preoccupies children; this includes sending threatening mobile texts, messages and emails and posting unpleasant comments and pictures on social websites. Forty per cent of children surveyed had experienced this form of bullying. Children who said they had been bullied felt depressed, unhappy and sometimes suicidal and had low self-esteem. More than half of

children (57%) thought that adult intervention had helped to stop the bullying, but 24% thought it had made no difference and 19% said it had made it worse.

'[Bullying would stop if bullies could] experience it themselves and if they could understand how people feel.'

'[Adults in schools] can tell ways to stop being bullied and they can exclude.'

104. JARs found that nearly all schools and children's services, including children's homes and children's centres, have policies in place to combat bullying and oppressive behaviour. Although there are joint strategies between agencies in some areas, other areas rely on individual schools and services to develop their own approaches. These strategies have yet to affect rates of reporting of incidents in most areas.

105. JARs showed that nearly all areas have undertaken an equalities impact assessment of children's services to determine whether service provision is supporting good outcomes for all children and young people. However, the impact of this assessment has not yet been demonstrated in most areas. Inspections have found a wide range of services designed specifically to address the needs of vulnerable groups of children and young people from minority ethnic groups. Some areas have also promoted multi-agency strategies to reduce racism and racial harassment. However, in others this is less apparent or well-promoted.

106. Children and young people who commit offences are more likely to have been exposed to bullying than other children. YOT inspections found that one third of all young people in the criminal justice system with an educational difficulty report that it is to do with being bullied, while 14% of those in custody report having been bullied while in education. There has been a significant increase in the use of restorative justice methods for bullying in the community. Inspections noted that there was an increase in the number of looked after children and young people who were being dealt with appropriately by their care establishment rather than through the criminal justice system (see example).

Example of the reduction of unacceptable behaviour

The Wolverhampton YOT noted that some children and young people without a criminal record who were placed in residential homes left the residential home with one. YOT staff discussed the issues with residential staff and meetings between staff and children and young people with persistently poor behaviour followed. These were conducted using mediation techniques and young people were asked to sign acceptable behaviour contracts. The children and young people felt they had been listened to and unacceptable behaviour was reduced.

107. Most youth offender institutions have comprehensive anti-bullying and violence reduction policies. However, important aspects of the policies are not always implemented, such as the provision of support for victims or the delivery of programmes and/or individually targeted interventions for those who have bullied. Levels of bullying, assaults and victimisation remain high. The results of surveys carried out by HM Inspectorate of Prisons indicate that the commonest type of victimisation is through verbally insulting remarks.[50] They also show that:

- 20% of boys and 13% of girls reported that they have been victimised by staff
- 26% of boys and 20% of girls reported victimisation by other young people
- in three out of 14 youth offender institutions, victimisation was reported as higher by staff than by other young people
- only 39% of boys and 56% of girls said that they thought they would be taken seriously if they told a member of staff they were being victimised.

108. Young black people in youth offender institutions reported significantly less favourably than their white counterparts on a number of themes. These include:

- higher levels of victimisation by staff (32% compared with 19%)
- less confidence of being taken seriously if they told staff they were being victimised (26% compared with 44%)
- higher levels of the use of force and adjudications (a formal punishment hearing).

109. Although staff in youth offender institutions are quick to respond to bullying, methods of dealing with it are often reactive and mainly punitive. With a few notable exceptions there is very little use of mediation or restorative justice and support for victims of bullying is underdeveloped. Few establishments have a policy or a range of specific interventions for managing vulnerable young people, whether they have been bullied or are vulnerable for other reasons, such as the nature of their offence. This leads to inconsistencies in their management within and between establishments. A few establishments have introduced multi-disciplinary meetings to discuss the management of individual vulnerable young people. These models usually rely on staff sharing available information at daily or weekly meetings rather than promoting a systematic way of identifying, assessing and planning care for individuals who require a higher level of support than the main population.

110. Managing factions from rival gangs and the associated victimisation poses particular challenges in prisons. Notable initiatives include a recent partnership between two youth offender institutions and the Manchester Multi-Agency Gang Strategy for monitoring gang members. Another establishment has developed an excellent intelligence database to help staff keep apart young people who pose a risk to others.

Conclusions

111. Inspections found evidence of a strong commitment by agencies to focus on the **wider safeguarding needs** of children and young people in addition to child protection. This is reinforced by the increasing integration of children's services and the shared framework provided by Every Child Matters. However:

- a shared, consistent understanding of safeguarding is still lacking, particularly between social care services and the criminal justice system
- there is a lack of a common approach to safeguarding across secure establishments (secure training centres and youth offender institutions), where the focus is largely on containment rather than on applying a proper balance between security and welfare needs.

112. The majority of settings where children are cared for or educated comply with requirements and regulations for **keeping children safe**. Inspections also found examples of good partnership working to prevent accidents to children. However:

- some children and young people continue to express significant levels of concern about their personal safety and about being bullied, particularly in institutional and secure settings
- there are concerns about standards of safety for children and young people in some fostering services, 10% of children's homes and most of the youth offender institutions that hold boys.

113. There is better identification of needs at an early stage and increasingly effective provision of **preventive and earlier intervention services.** These include services provided by children's centres and preventive services to tackle substance misuse by children and young people. Key areas for improvement include the following:

- The continuity of funding for some preventive services, such as sex education, is uncertain, which constrains service provision.
- Dedicated programmes have started to reduce the incidence of teenage pregnancy, but have yet to make a significant impact on teenage pregnancy rates.
- Drug and alcohol misuse remains a significant factor in offending behaviour but young people leaving custody may fail to access mainstream substance misuse services since work carried out in custody is not consistently available or always followed up in a timely way.

114. Most areas consider that they are making progress towards comprehensive provision of CAMHS. Service provision is increasingly appropriate to the age of the children concerned and children's centres are helping to promote mental and emotional health. There remain significant shortcomings:

- a shortage of suitable hospital beds for children in some areas and long waiting times for access to services
- limited access to secure mental health beds for children and young people in custody, who often have to wait several months to be assessed
- a continuing lack of adequate provision for children and young people with learning difficulties and/or disabilities.

115. Many areas have identified **domestic violence** as a high priority area for action. Joint working arrangements

to combat domestic violence have been strengthened, particularly between the Crime and Disorder Reduction Partnerships, children's services, the police and health services. The police, NPS and CPS have clear arrangements for dealing with cases of domestic violence. However:

- a fifth of LSCBs identify combating domestic violence as a high priority but have yet to demonstrate the impact of their work on outcomes for children and young people
- responses by the NPS to the needs of children and young people who commit offences and who have a background of domestic violence were judged inadequate in half the cases reviewed
- practitioners in Cafcass, which has a role in identifying and safeguarding children who are affected by domestic violence, vary significantly in their knowledge and understanding of domestic violence.

Recommendations

Government

- The DCSF, the Department of Health and the Ministry of Justice should increase and better target CAMHS in order to improve access to these services for children and young people with learning difficulties and/or disabilities and those who are in the criminal justice system.

Government, agencies providing services to children and young people and relevant inspectorates

- All government departments, agencies and relevant inspectorates should specifically include the impact of domestic violence on children and young people within their risk assessments for planning, delivering, evaluating or inspecting safeguarding services.

Introduction

116. This chapter considers the following groups of children who are particularly vulnerable and/or need targeted interventions or special services:

- looked after children
- care leavers
- missing children
- young carers
- children in the family justice system
- children who are victims of, or witnesses to, crime
- children and young people who commit offences
- children in secure settings
- children using health services
- children with learning difficulties and/or disabilities
- asylum-seeking children
- children from minority ethnic groups
- children and young people in the armed forces.

117. The second *Safeguarding children* (2005) report considered many of these groups. In each case, this chapter shows what has changed since 2005 and what remains to be done to ensure that children's specific needs are considered and that they are adequately safeguarded.

Looked after children

118. Children and young people who are looked after by local authorities are among the most vulnerable. Agencies have strengthened safeguarding arrangements considerably since Sir William Utting's landmark report *People like us* brought their situation to light in 1997. However, these improvements are yet to be translated fully into improved outcomes for children and young people. The second *Safeguarding children* (2005) report noted examples of good practice and better working arrangements between agencies. Nonetheless, there were examples of poor practice and the needs of looked after children were still not given sufficient recognition or priority.

119. The Children and Young Persons Bill 2008 proposes to reform and strengthen the statutory framework surrounding the care system. It therefore has a significant focus on looked after children. Its provisions, if enacted, aim to ensure that children receive high-quality care and support and to promote improvements in the delivery of services.

120. Children are looked after in a variety of settings: in children's homes, residential special schools, foster care and adoptive families. On 1 January 2008, Ofsted had responsibility for inspecting 1,995 children's homes, 276 independent fostering agencies and 149 local authority fostering agencies in England. The number of children and young people admitted to care has reduced (figure 3) but children and young people are staying longer in care. Changes over time in the gender and ethnicity profile are small, as are those in the age profile. Numbers of looked after children and young people from black and minority ethnic groups are increasing but remain under-represented compared with the profile of the total population. The most significant increase is in numbers of young people from Asian or Asian British communities. The national picture masks considerable variations between regions. The north west, West Midlands and outer London regions have shown significant increases in numbers of children in care, while numbers have decreased elsewhere. The rate within inner London is reducing but remains significantly higher than elsewhere.

Figure 3: Numbers of looked after children 2004/05 – 2006/07

	2004–05	2005–06	2006–07
Total numbers of looked after children (at 31 March)	61,000	60,300	60,000
Children who started to be looked after	24,900	24,600	23,700
Children who ceased to be looked after	25,900	25,900	24,700
Gender (at 31 March)			
Male	55%	55%	56%
Female	45%	45%	44%
Ethnicity (at 31 March)			
White	79%	79%	78%
Asian or Asian British	2%	2%	3%
Black or Black British	8%	8%	8%
Mixed ethnic background	8%	8%	8%
Other	1%	2%	2%

Source: DCSF; the figures are rounded.

121. Most local authorities have clear thresholds for admitting children into care and effective gatekeeping processes exist to support children and young people to remain safely within their families or communities. However, evidence from JARs shows that only the most

targeted family support has an impact on reducing numbers of looked after children. Examples include family conferences, children's centres for assessing parenting skills and rapid response teams for family breakdown. Furthermore, access to such services is very variable, and is especially limited in rural areas.

122. Regulatory and service inspections show that multi-agency arrangements for the care of looked after children are improving. However, this conceals much variation in practice and one in 10 children's homes and fostering services are judged to be providing an inadequate service for the children in their care. An important feature of those services that are judged outstanding is that they do all the important things well that have a direct impact on looked after children and young people. They perform well across the range of national minimum standards, regulation and guidance relating to assessment, care planning, healthcare, education support and day-to-day personal care.

123. Nearly all local authorities have established corporate parenting boards comprising members and officers from local authority departments and from agencies that deliver children's services. Most boards consult with looked after children, but children placed with foster carers or families are less likely to take part in consultation activities. Corporate parenting boards have helped to raise the profile of looked after children in their areas. However, the role of the corporate parent is not yet fully understood by all members and officers and its impact varies considerably. The most effective boards have strong leadership and rigorously challenge performance in all aspects of care. They have contributed to improving compliance with assessment, care planning and review processes, strengthening joint working arrangements and increasing access to leisure activities for children.

124. The national indicator set for children's services shows that placement stability for looked after children and young people has improved. Nearly all local authority areas are performing at a good or better level in ensuring that children and young people have no more than three placement moves in their first year. Nationally, 12% of looked after children had three or more placements in 2006–07, an improvement on 2004–05. In relation to long-term stability, an indicator introduced for 2007 showed that, nationally, of the children who had been looked after continuously for at least two and a half years, 65% had either been living in the same placement for at least two years or were placed for adoption. This has been achieved through effective monitoring, improved planning for security for children in their placements and better commissioning of placements. The better local authorities are establishing joint commissioning supported by robust monitoring of contract compliance. A clear commitment to maintaining children within their local communities has resulted in a reduction in out-of-area placements. Most local authorities have also entered into collaborative regional arrangements to strengthen commissioning of these placements.

125. However, placement choice remains limited for nearly all children, especially for children from minority ethnic groups, sibling groups and children with complex needs. They are more likely to be placed more than 20 miles from their home. In 2006–07 one third of local authorities placed at least 14% of their newly looked after children more than 20 miles from their home.

126. JARs found that there has been slow progress in raising public awareness about the statutory requirement on carers to notify councils of children in private fostering arrangements and in providing support for these children. Where promotional activities have taken place, they have included information about private fostering, multi-agency training and clear processes for the monitoring of arrangements. However, such initiatives have often made little impact on the overall rate of notifications and the number of children known to be in private fostering remains an unknown in nearly all local authority areas. Regulatory inspections also judged six out of 16 area private fostering arrangements to be inadequate. Areas that have successfully started to tackle the problem have promoted information about private fostering, carried out multi-agency training and developed clear monitoring and scrutiny.

127. Planning arrangements for individual children and young people vary from outstanding to inadequate. The quality of individual care plans and supporting plans for health and education arrangements is also very variable. Compliance with statutory reviews of care arrangements for looked after children has improved overall. The participation of children and young people in their reviews has also increased. Nationally, 85% of reviews were completed within the timescales in 2006–07, but nearly a quarter of local authorities are performing below an acceptable level.

128. The monitoring of the health and well-being of looked after children has improved in nearly all local authority areas. Nationally, 85% of looked after children had their teeth checked and a health assessment in 2006–07. Regulatory inspections paint a less favourable picture, particularly in relation to the safe management and administration of medicines to children in residential settings. As the second *Safeguarding children* (2005) report found, arrangements for securing health services for children in out of area placements are not so effective as for those placed in their home area. Fast-tracking arrangements to specialist CAMHS and therapeutic services are effective in nearly all areas for children with high levels of needs, such as risk of self-harm. Children with lower levels of need, such as behavioural difficulties, often have to wait long periods before receiving an assessment or treatment

129. Most areas have strengthened planning and operational arrangements to support the education of looked after children. Designated teachers for looked after children exist in schools in nearly all areas, carers encourage children to attend and achieve and most children have personal education plans. However, these arrangements have not yet had a significant effect on raising attainment and attendance levels. The educational attainment of looked after children is slowly improving, but lags behind that of other children. In 2006, 13% of looked after children achieved five or more A*–C grades in GCSE compared with 62% of all 16-year-olds, and 64% gained at least one GCSE compared with 99% of all 16-year-olds.[51] School attendance by looked after children is also a matter of concern. The proportion of looked after children who missed at least 25 days of schooling rose from 12.6% in 2004–05 to 13.0% in 2006–07. Looked after children who go missing also account for most of the cases of missing children that are reported to the police.

130. There are good initiatives to secure children's participation and children themselves say the quality of service is improving. Children's advocacy arrangements have been strengthened in most areas, but the uptake is limited particularly for children in foster homes. Complaints procedures are still not promoted or managed well in all local authorities. Some children feel that it is hard to influence decisions once they have been made by someone in authority:[52]

'Allow us a real say in decisions affecting us.'

'Even when you decide we don't understand something ... still ask what our views, wishes and worries are.'

131. The proportion of looked after children who are allocated to a named, qualified social worker was 95.5% nationally in 2006–07, an improvement on 2004–05 (93.4%). Where there is shortage of qualified social workers, nearly all looked after children have access to a named worker. Nonetheless, children and young people in most areas continue to experience frequent changes of social workers, often arising from staff turnover. Vacancy rates are falling and there is evidence that workforce strategies are starting to have a positive impact on recruitment and retention rates in children's services.

132. The quality of front-line social work practice across the range of services for looked after children remains variable. This has a direct impact on the experience and well-being of these children. The quality and frequency of contact with front-line staff is an important factor in making children and young people feeling safe and valued. Some children surveyed found it difficult to contact their social worker directly.[53] Others found it difficult to raise problems or concerns in the setting where the problems arise, and 87% said their social worker normally visited them in their care setting.

'If something is wrong, you should be able to ring them.'

'Every social worker could have an emergency care phone so you could ring the number.'

'[A good social worker will] act on early signs of problems.'

133. Inspections of regulated services that are judged to be only adequate or inadequate frequently drew attention to the lack of experienced and competent staff and poor compliance with requirements for supervising staff in children's homes. Areas for improvement most frequently noted in inspections were training in child protection procedures and behaviour management. Eight per cent of regulatory inspections raised issues about methods of control, including lack of guidance on acceptable methods of restraint and in a few cases the use of unacceptable methods, such as requiring a child to wear specific clothing.

134. Looked after children are more likely to enter the criminal justice system than other children. Three per cent of all children enter the criminal justice system, but 10% of first time entrants are looked after children. In the sample of 226 children and young people in YOT inspections, 17% in custody were looked after at the point of sentence. In surveys carried out in youth offender institutions 29% of boys and 44% of girls reported that they had been looked after at some point in their lives.

135. Some YOTs have created specialist posts to address the needs of looked after children and young people and there are numerous examples of good liaison with social care services. However, inspections judged that 25% of social care services did not provide an adequate service for their looked after children and young people in custody. In addition, one in six YOTs experienced a reduction in social worker contact with looked after children who had been sentenced to custody. Several examples were noted of social care services inappropriately transferring to YOTs all responsibility for social care duties for those remanded to local authority secure accommodation (a responsibility which is non-delegable). Since YOT workers are not always able to access the same full range of provision as social workers, these children were consequently denied the services they needed. It also disrupted the relationship established by the local authority social worker with the child, leaving the child potentially unsupported once contact with the YOT ceased if, as often happened, their cases were not picked up again by children's services. The Children and Young Persons Bill 2008, if enacted, contains provisions to ensure that regular visiting of looked after children in custody takes place.

136. All youth offender institutions now have dedicated social work posts whose remit includes ensuring that the needs of looked after children and care leavers are met. This initiative has not only provided much-needed support for individual children in prison but has also helped to establish recognition of looked after children as a group with specific needs. Social workers had started to work well with prison-based family support workers or develop family liaison services where none existed. They were also beginning to liaise with social workers in the home areas of children who need support on release from custody. In addition, they were providing much-needed support through the investigation process to individual children who had disclosed abuse. However, there has always been uncertainty about the ongoing funding of these posts, which has been provided only on a 12-month basis each year, as described in paragraph 25. The lack of job security this represents for social workers has had an adverse effect on the development of the posts in individual establishments and on the task of raising the profile of youth offender institutions with LSCBs.

Care leavers

137. Young people leaving care are less likely to succeed in life than those who have been brought up by their parents and are more likely to enter the criminal justice system, or to have been in it prior to leaving care. Rates of educational attainment for care leavers have increased between 2004–05 and 2006–07 although the level of attainment is still poor. However, the percentage of care leavers who were in employment, education or training at age 19 in 2006–07 was 76% of the rate of 19-year-olds in the general population.[54] Unaccompanied asylum-seeking children leaving care are considered in the section on children seeking asylum later in this chapter.

138. The Children (Leaving Care) Act 2000 places a number of duties on local authorities, including:

- to assess and meet the needs of young people aged 16 and 17 who are in care or are care leavers; local authorities should keep in touch with care leavers until they are at least 21
- to provide a comprehensive pathway plan for every eligible young person in care when they reach 16; this should set out a clear route to independence
- to provide a young person's adviser to coordinate the provision of support and assistance, with particular emphasis on education, training and employment.

139. JARs found compliance with pathway planning requirements by local authorities has improved. Between 2004–05 and 2006–07 the proportion of eligible young people with a pathway plan rose from 79.6% to 86.1%. Compliance with requirements for all care leavers to have personal advisers was also better. Over the same period, the proportion of eligible young people with an allocated personal adviser rose from 93.9% to 95.5%.

140. Joint working arrangements between agencies are

generally good. This was borne out by YOT inspections which found good contact between YOTs and leaving care services and active involvement of YOTs in pathway planning. Transition planning is well-managed in most areas and financial support is broadly consistent between local authorities. Some areas help increasing numbers of care leavers to remain with their foster carers after their 18th birthday.

141. Lack of suitable housing remains the area of greatest concern. In 2006–07, at their 19th birthday, 87% of care leavers who were in contact with councils were assessed by the council to be in suitable accommodation.[55] However, this means that 13% were not in such accommodation. Choice of housing is limited and some care leavers do not feel safe in their accommodation. Lack of safe accommodation is a particular issue for young people who have been in the criminal justice system, particularly those who have been in custody, and is not restricted simply to former looked after children. The use of bed and breakfast accommodation for care leavers has reduced, but still remains too high. Such accommodation is particularly unsafe as there are no requirements for the vetting of other residents, who are often adults.

142. Young care leavers themselves consistently raise the lack of appropriate accommodation as a problem and reject councils' assessment of their accommodation as suitable. Work by the Children's Rights Director reveals that care leavers spoke of having to wait months or longer in local bed and breakfast accommodation before the promised flat became available. A number of them raised concerns about the cleanliness of accommodation and its location in unsafe areas. Some described having to live in accommodation that also housed adults and young people with whom they would never have been allowed to mix while in care.

'The places they put you are not any good – there are no positive role models. You are around people who have no jobs and sit around all day.'

'[I'm] living in a hostel with fellas and drug addicts.'

'They put me in a hotel ...They tried to do it with me, but [I] had my uncle who sorted me out, he stepped in and helped me out, what if you've got no one to help you.'[56]

143. Government initiatives aim to give greater priority to the needs of care leavers. The provisions of the Children and Young Persons Bill, if enacted, will give children up to 18 more influence over moves to independent living and ensure they retain support and guidance as long as they need it. Also, the new National Indicator Set for Local Government, which underpins the delivery of Public Service Agreements, will include an indicator specifically on care leavers in suitable accommodation.

Missing children

144. Some children run away or go missing from home or care, but no single agency has responsibility for maintaining reliable statistics on the numbers of children involved. Information about the scale of the problem is fragmented and inconsistently collected between agencies such as children's services, police and the voluntary sector. There is considerable variation across LSCBs in the extent to which they monitor the incidence of missing children. However, some LSCBs have developed guidance for staff to help staff across agencies identify potential causes for children running away such as forced marriages, bullying and sexual abuse. Many children enter care because they have been abused, neglected or rejected by their families and, although no immediate danger may be identified, these children can be vulnerable to longer-term risk. Looked after children account for the greatest proportion of the missing person reports received by the police. Close cooperation and good working arrangements between agencies are important factors in finding these children and in identifying and resolving the problems that led to them going missing, where they have run away (see example below).

Example of proactive work by Cheshire Constabulary to reduce the number of young missing persons

In 2002, data collected by Cheshire Constabulary on young missing persons highlighted a growing problem in Warrington. There were 820 reported incidents that year at a cost of nearly £2.8 million. This includes the cost of the missing person investigation and the investigation of associated crimes committed by and against the missing persons.

Continued...

Continued...

The force worked with statutory and voluntary sector partners, as well as with at-risk groups and families to develop the 'Talk, don't walk' project. A detective officer with an extensive background in child abuse investigations coordinated referrals to an assessment service, a consistent approach was applied to 'return to home' interviews and support workers were provided for family members. There was also an awareness-raising campaign and a 24-hour helpline developed in partnership with the National Runaway Helpline. The police project worker's role has become the template for best practice in missing from home coordination. The number of incidents has fallen by 256, with estimated cost savings of just over £1 million.

145. JARs found that protocols are in place in most areas between social services, the police and health services for sharing information about children who go missing. Arrangements for tracing these children have improved, especially for those who are missing from care settings or education. Most areas have robust processes to identify children missing from school and from home and to agree a multi-agency action plan to trace the children. This is helping to reduce the numbers in most local authorities of children whose whereabouts are unknown. More attention is also being paid to reintegrating children who are found into schools and children's homes. This has contributed to a reduction to 7% nationally in the numbers of young people, aged 16–18 years, who leave school and whose situation is unknown. However, in most local authority areas, operational protocols are yet to be supported by clear over-arching approaches to collecting and recording date to ensure that the whereabouts of all children and young people in the area – and particularly those who are not of school age or on school rolls – are known. Arrangements for communicating the movement of children across local authority borders have also improved, although the responsible authorities still do not always inform the host authorities when looked after children move into their area. The second *Safeguarding children* (2005) report found this to be a problem.

146. ACPO has issued comprehensive guidance to police forces on the management, recording and investigation of missing persons. Risk assessment provides the basis for both priority and lines of enquiry. Good recording and information management are an important element of this process. Although the majority of forces (87%) have dedicated IT systems to support missing person investigations, HM Inspectorate of Constabulary's programmed inspections in 2007 found that lack of or ineffective IT in around a third of forces was hindering:

- consistency in recording information and, consequently, the quality of risk assessment
- the timeliness of missing person reviews
- the ability to supervise effectively and audit the quality of investigations and reviews and test policy compliance
- the ability to produce management information to develop problem profiles.

Conversely, the best performing forces not only tended to have effective IT systems in place but demonstrated:

- well-developed intelligence led approaches to missing persons investigations
- the development and use of problem profiles to identify opportunities for preventative work
- well-developed partnership responses in priority areas such as looked after children missing from placements.

147. Children are conscious of the dangers of running away and many are concerned that children are not good at protecting themselves while they are missing.[57] Some suggested that there should be safe places to go if children and young people felt they had to run away, so that they would not be in danger on the streets. Children also felt strongly that they should have the opportunity to discuss their reasons for running away with an independent person to help address the underlying problems.

'If we return from running away, we need to be able to talk things through, when we are ready, with someone from outside the place we ran from, and if we are running from something we couldn't cope with... then something should be done to sort out these problems.'

'When police return absconders to establishments they ran from, the police should provide the opportunity for the young person to tell an independent counsellor why they ran away and if there is anything that needs to be sorted out – in some cases, the young person might be running away from something they cannot cope with.'[58]

Young carers

148. The existence of children and young people who provide care for a parent or relative is increasingly acknowledged, although it is unclear how many children act in this role. It is clear, however, that their caring responsibilities may cause them to miss out on educational and leisure opportunities and adversely affect their safety or welfare. They may cause emotional, psychological and physical difficulties for a young carer.

149. JARs found that awareness of the needs of young carers has increased across children's services and in schools. Good-quality services are in place in most areas for young carers, often delivered in partnership with the voluntary sector. Services are tailored to support young people to attend schools and leisure services and are informed by the views and wishes of young carers. However, processes for identifying young carers are less well-developed in most areas. This makes it difficult to plan the capacity to meet potential demand for services. The Government is considering the needs of young carers as part of a current review of the Carers Strategy.

Children in the family justice system

150. Cafcass has a statutory responsibility for safeguarding and promoting the welfare of children in family proceedings in England where their welfare is or may be in question. These involve, for example, care proceedings, adoption or contact and residence arrangements for children whose parents are separating or divorcing. The outcome of these proceedings usually has a considerable impact on the lives of the children involved. In 2006–07, Cafcass dealt with nearly 24,000 private law cases and almost 13,000 public law cases.[59] Overall, more than 80,000 children and young people were involved. Including all its support work with contact centres, Cafcass estimates that it is involved with around 100,000 children every year.

151. The second *Safeguarding children* (2005) report noted that there was an inconsistent understanding of the term 'safeguarding children' by Cafcass and the courts. There was no explicit safeguarding agenda for children building on their commitment to promote children's statutory rights. Children seldom had any say in formal arrangements about their future and the courts rarely encouraged children to attend, except in adoption cases. There were also significant delays in allocating Cafcass staff to cases.

152. Since then, the profile of Cafcass within the family justice system has increased. Attention to safeguarding issues within Cafcass at a strategic level has also increased. Cafcass issued a Safeguarding Framework in 2007 to inform practitioners' work, pulling together all procedures and guidance relating to its duty to safeguard and promote the welfare of children. This is yet to make a significant impact on front-line practice. A major restructuring is currently in progress to give greater priority to front-line services and to strengthen lines of accountability, but it is at too early a stage to show positive results.

153. Inspections have also noted some improvements in performance. There has been a reduction in delays in case allocation in most parts of the country. Similarly, there have been reductions in the duration of care proceedings, to which Cafcass has contributed, although they are still considered too long. Cafcass has made progress in increasing the participation of children and in strengthening the voice of the child in care proceedings. There remain considerable weaknesses in private law reporting, where the available options are not always fully analysed or considered.

154. Despite these improvements, Cafcass continues to experience difficulties in ensuring compliance with policies and procedures at front-line level. Inspections in late 2007 found practice to be inadequate: it was often poor, and insufficient attention was given to safeguarding children by front-line staff. This led to inspectors of one Cafcass region referring five cases to the regional director for immediate review to ensure that children were not left at risk of harm. Inspection of another region found similar shortcomings and practice that was inadequate.

Specific issues included poor risk assessment, case recording which widely failed to comply with Cafcass requirements and lack of proper recording of assessments in a number of cases. These failings were compounded by lack of clarity about managerial accountability and poor quality assurance arrangements.

155. Targeted inspection work on children's guardians found that the quality of their work in care-related proceedings was inconsistent.[60] Insufficient guidance from Cafcass about how the task should be carried out had led to an over-reliance on practice experience and personal working styles. This undermines the credibility of children's guardians' reports to the family courts and may disadvantage adults whose parenting capacity is being scrutinised. There was also confusion about the respective function of children's guardians and local authority social workers and a need to clarify professional boundaries and avoid overlap.

156. The Cafcass Board agreed a three-year modernisation programme in February 2008, of which one of the key elements is practice and performance improvement.

Children who are victims of, or witnesses to, crime

157. As the second *Safeguarding children* (2005) report noted, children and young people who are victims of and/or witnesses to crime need special care. YOT inspections found there are few clear, targeted services for children as victims of crime, either to achieve 'closure' or to provide direct or indirect reparation. There has been an increasing emphasis on mediation and restorative justice in schools and other public service settings, but it relies very much on local initiatives. Several individual examples of sensitive practice enabling the victim to achieve closure stood out. However, these were too few and insufficiently embedded in the work of the YOTs to inspire confidence that they are taking into account the specific needs of children as victims. In addition, inspections of probation services found that children's safeguarding or the needs of victims arising from specific offenders required greater attention in over one third of relevant cases (37%).

158. The CPS prosecutes people, including children and young people, who have been accused of a criminal offence. It advises the police on cases for possible prosecution, reviews cases submitted by the police and prepares and presents cases in court. The CPS published its policy relating to children and young people as victims and witnesses in June 2006 and has recently circulated guidance to Area staff.[61] The policy is a public statement of CPS practice, bringing together the Prosecutors' Pledge and the Code of Practice for victims of crime and the draft witness charter. It promotes consistency of approach across CPS Areas and encourages staff to understand and respect the differences between children.

159. The Crown prosecutor usually discusses cases face to face with investigating officers when making the decision to charge or not, but this may be done over the telephone or, on occasion, on submission of a file. Prosecutors should consider the views and needs of the victims in conjunction with the investigating police officer in making any charging decision. CPS inspections and assessments showed that relevant victim and witness issues were generally taken into account, although comprehensive consideration of needs was not evident in every instance, for example the need for special measures (see paragraph 162) or the likelihood of a child's attendance at court. An audit review of file management and organisation further demonstrated that witness issues were not being effectively considered at the first review of the file. Only 35% (62 out of 168) of cases had some comment at initial review on witness needs. Such failures can result in late identification of witness needs, which could delay case progress or affect the successful outcome of the case.

160. Under the Direct Communication with Victims scheme, the CPS communicates any decision to drop or substantially alter a charge directly to the victim, rather than via the police, giving as much explanation as possible. In a recent audit,[62] 84% of the letters sampled gave adequate explanations, which clearly set out why the decision had been taken to terminate the case or alter the charge, and 91.4% of letters conveyed a sense of empathy. There were examples of good-quality letters for more serious cases, including cases of child abuse. The less satisfactory letters lacked sufficient explanations and showed a lack of empathy with the victim, including in some child abuse cases. It was also of concern that cases involving vulnerable and intimidated victims were not always accurately identified as requiring a letter, including sensitive cases with child victims. Consequently, in some cases letters were not sent.

161. Arrangements have been introduced in recent years for the management and support of vulnerable witnesses. They have promoted greater attention to the needs of children who are required to attend court hearings, for whom the experience can be particularly intimidating and confusing. Under the Government's 'No Witness, No Justice' scheme, the establishment of witness care units (WCUs) has provided a single point of contact for victims and witnesses. CPS, police and, in some cases, Witness Service personnel staff the WCUs. As a minimum requirement WCUs carry out an initial assessment of a victim's needs followed by full assessment before the trial. These determine whether there are issues that might prevent witnesses giving evidence or attending, such as fears of intimidation or language problems. Overall performance assessments of the CPS Areas found that WCUs were meeting some of the minimum standards but the majority were still working towards meeting them all. A number were giving priority to meeting the appropriate level of service for vulnerable and intimidated victims and witnesses, including children.

162. Children or parents and carers can complete optional victim personal statements, which provide an opportunity to describe the impact of the crime on the child. Special measures have also been developed for witnesses who are children and certain categories of adult when they attend court. They include the giving of evidence over a live video link or behind a screen, using a witness intermediary, giving evidence in private or the removal of gowns and wigs in the Crown Court. Where the victim and witness aspects were fully inspected, CPS inspections found some variable performance in relation to special measures. These included shortcomings in the early identification and timeliness of applications for special measures, which should be made within 28 days from the service of papers. Joint inspections of CJB Areas found that procedures were generally in place for identifying those in need of special measures and witness protection and there were examples of innovative practice (see example below). In many cases, special measures were often limited to the standard special measures procedures of video links or screens.

Example of the use of special measures for child witnesses

The Devon & Cornwall CJB developed an effective partnership with the NSPCC across the area. Facilities are in place in Exeter to allow child victims and witnesses to give video evidence from NSPCC offices, removing the additional trauma of attending court. These facilities have also been used in cases of domestic violence where both parent and child have been required to give evidence.

163. HM Inspectorate of Court Administration found that courts generally treated child witnesses with care and sensitivity and had developed innovative practices to help children (see examples below).[63] However, facilities for children varied considerably between court premises. Crown Courts were found generally to provide more child-friendly facilities, even though many trials in magistrates' courts involve child victims and witnesses. There was variation between court service areas about the respective roles of witness service volunteers and court ushers when accompanying children into a video link room. This meant that a suitably trained person did not always accompany child.

Examples of HM Courts Service services for children

In Humber court service area, the Young Witness Service developed a simple system to allow a child giving evidence by video link to indicate a need for a break. The volunteer raised a yellow card if the child needed to use the toilet or a red card if the child was becoming distressed. The cards were visible to the judge, who could take appropriate action.

The child witness waiting room at Grimsby Combined Court is suitably decorated and equipped. It includes a wooden model of the courtroom with wooden dolls, which young children – with their parents and the Witness Service volunteer – can use to learn about the court process and the participants in the hearing.

Children and young people who commit offences

164. Children who commit offences pose particular challenges for safeguarding. They are more likely than the majority of children to have been looked after, to have been abused or to have experienced domestic violence. Many have health or mental health needs that have gone undetected or untreated. The most recent available information about children and young people who offend is that for 2005–06.[64] This shows that young people committed around 302,000 offences in that period – an increase in offences of 11.4% since 2002–03. There were around 212,250 court outcomes (disposals), dealt with in various ways (figure 4).

Figure 4: Court outcomes of young people who committed offences 2005–06

Type of court outcome	Number of children and young people (aged 10–17)
Pre-court decisions (e.g. police reprimands and final warnings)	94,500
First tier orders (e.g. discharges, fines, compensation orders)	73,800
Community orders (e.g. supervision orders, drug treatment and testing orders)	36,800
Custodial sentences	7,100

Source: YJB 2005–06; the figures are rounded to the nearest 100.

Young people prosecuted for an offence

165. Young people charged with offences normally appear at a Youth Court where they are bailed or remanded in custody. If a young person is charged with a grave offence, or a serious offence if jointly committed with an adult, the case may be committed to the Crown Court. In 2006–07, a total of around 121,650 prosecutions of young people were carried out, of which around 101,200 were successful.

166. The CPS has taken over the responsibility from the police for making decisions about whether to charge in the more serious or contested cases. The CPS thereafter reviews, prepares and prosecutes cases in the courts. CPS Youth Justice Co-ordinators and specialists have been appointed within CPS Areas and have headquarters guidance on their role and responsibilities. Headquarters holds regular conferences for coordinators. In addition, the CPS holds annual interagency youth conferences for CPS youth specialists and other specialists from other agencies within the criminal justice system, for example defence solicitors. The CPS Youth Offender Policy stipulates that wherever possible cases in youth remand courts should be prosecuted by a CPS specialist. Clear guidance exists for youth cases generally and to assist prosecutors in determining the public interest when considering the prosecution of young people.

167. The handling of youth cases is mostly satisfactory, with clear evidence of good work. Inspection data from cases examined as part of area effectiveness inspections (AEIs) indicates that youth cases are appropriately prioritised. Within the CPS Areas youth cases are usually allocated to youth specialists. There is evidence that specialists prosecute these cases at court to ensure that progress is made. A few cases are allocated to non-specialists or agents, which can raise concerns about their level of experience in dealing with youth cases and their ability to prioritise and progress such cases effectively.

168. For persistent young offenders, the government target for the average time from arrest to sentence is 71 days.[65] Areas monitor local performance against this target with partners at the local CJB. It is also monitored at a national level by CPS headquarters. The 71-day target for the average number of days from arrest to sentence was not met for the year to December 2006 (72 days). However, the rate is improving and has reduced to 62 days for the most recent rolling quarter ending February 2008.

169. Children and young people must be kept separate from adults charged with an offence while at police stations, courthouses or when being transported between them, unless the adult is a relative or a person jointly charged. HM Inspectorate of Court Administration inspections of Youth Courts found that waiting areas for young people are normally separate from those for adults.[66] However, young people sometimes have to pass through adult waiting areas to gain access to other

facilities, such as refreshments. There is particular concern where young people are escorted through public areas of the court to get from a custody area to the courtroom. Waiting areas are comfortable but generally lack useful information, such as a description of the court process. Where there is not a separate Youth Court, most courts provide a separate youth day.

170. The Youth Courts are normally able to provide the special measures applied for, such as screens or video facilities. In some cases, the Youth Court does not have the necessary equipment for video-links. This has led to moving the case to a formal courtroom that can provide this equipment. Moving from an informal to a formal courtroom can make it harder to engage with the defendant, although most courts attempt to minimise the number of times such a move happens.

171. Young people can be remanded or sentenced to custody at youth offender institutions, secure training centres or secure local authority accommodation. Escort to this accommodation is the responsibility of the YJB, but the courts provide holding accommodation while young people await escort. Inspections found that custody facilities at court range from good to unacceptable. In one courthouse, inspectors considered the accommodation provided to be dangerous. It was an isolated room with potential ligature and self-harm points and YOT staff confirmed that young people were often confined there unaccompanied. The court immediately removed the room from use.

172. Inspections also raised concerns that young people could spend several hours in court custody while awaiting escort. In addition, there was widespread confusion about who is responsible for young people remanded or sentenced to local authority secure accommodation while they are still on court premises, despite clear guidance that it is a local authority's children's service responsibility. This resulted in vulnerable young people being left unaccompanied and in unsuitable accommodation on occasion. There was similar confusion about responsibility for ensuring that key documents accompany the young person to a secure establishment. Consequently, custodial staff can lack the necessary information to carry out initial assessments and vulnerable young people may be at an additional and unnecessary risk. These were also findings in the second *Safeguarding children* (2005) report.

Preventing offending and managing children and young people who offend

173. YOTs play an important role in taking an overview of children and young people who commit offences throughout their involvement with the criminal justice system. Every local authority area with social and education services has set up a YOT to help prevent offending by children and young people. These multi-disciplinary teams normally include social workers, probation officers, police officers, and health and education staff.

Examples of work to prevent or reduce offending by young people

An evaluation of a Crime Diversion Scheme in Surrey shows that young people are being diverted from crime and continue to engage in youth development services programmes.

In Islington, young people have initiated a crime prevention mentoring scheme with the help of the YMCA.

The Positive Futures Programme in Swindon has achieved national recognition for its impact on reducing anti-social behaviour. The number of anti-social behaviour orders issued is low and parents are involved at an early stage when incidents occur.

174. Inspections of YOTs and probation services found many examples of individual good practice in direct work with children and young people. They also found a wide range of operational relationships between YOTs and social care services. The effectiveness of these relationships is critical to achieving positive outcomes for children and young people but they ranged from excellent to poor. Only 54% of YOTs inspected had sufficient or better joint working and coordination arrangements with social care services. Shortcomings were noted in communication, the definition of roles and responsibilities, agreement about thresholds for access to services, the implementation of protocols and information-sharing. Although YOTs are increasingly being brought into children's services, inspections have not identified a noticeable improvement in practice.

175. While many social care services are providing funding for YOTs, decreasing numbers are seconding currently experienced social workers to YOTs. This diminishes the capacity of YOTs to utilise their skills in and knowledge of safeguarding. It also reduces effective liaison between YOTs and social care. Education and learning services often provide secondments of suitably trained and experienced staff who provide links to both statutory and post-16 education, training and employment. The police and NHS trusts second staff in places, but there are increasingly fewer secondment arrangements with probation services, whose input is progressively delivered through funding instead.

176. YOTs did not address safeguarding sufficiently in 29% (88) of 305 sample cases reviewed – in some areas this was as high as 45%. Two thirds of YOT inspections resulted in at least one recommendation relating to safeguarding children. Increasing proportions of children and young people are considered a risk to themselves (31%), while proportions of those at risk from others are also increasing (17% overall). However, in 27 out of 31 YOT inspections there were examples of poor attention to safeguarding or vulnerability issues in the pre-sentence reports that YOTs produce for the courts. There were similar findings in probation services inspections, where fewer than half the cases involving safeguarding issues showed evidence of managerial involvement.

177. Home visiting plays an important part in the assessment and monitoring of the circumstances of children and young people. However, one third of children and young people involved with the YOTs inspected did not receive home visits. In the probation inspections, where reported, the figures were even lower for visiting that is commensurate with need: only half (51%) of cases were judged to have received sufficient attention.

178. Almost 25% of YOT areas inspected had recommendations relating to the lack of safe accommodation for vulnerable and homeless children under 18. These are children who are considered to be intentionally homeless, or are not deemed eligible for accommodation and maintenance by social care services or who have particular support needs that are not provided for through Supporting People funding. In some cases recommendations concerned the lack of community-based accommodation for those remanded to local authority accommodation. There is a decreasing amount of dedicated provision of such accommodation. In other cases recommendations concerned accommodation for young people transferring to the community following a custodial sentence.

Health and education services for children and young people who offend

179. Children and young people who commit offences have a range of needs that distinguish them from non-offending children. They are more likely to have witnessed violence in their home or to have been the victims of crime themselves. They often have difficulties in gaining access to mainstream health services because of a lack of parental support. Around 15% of children in the overall YOTs inspection sample had identified physical health needs. This rose to 29% of those in custody. Similarly, 41% of these children and young people had mental or emotional health needs, which rose to 60% of those in custody (see the section on CAMHS in Chapter 2 for more details about CAMHS provision).

180. A joint review of 55 YOTs found that many young people who commit offences have insufficient access to healthcare.[67] Although there have been improvements, especially in access to CAMHS and substance misuse services, substantial areas for improvement remain. One in six YOTs did not have a healthcare worker, even though PCTs have a statutory duty to provide one, and one third of YOTs did not have a mental health worker despite the obvious need for them. More recent inspections found that, at the point of imposition of a custodial sentence, only about half of young people were the subject of planned healthcare, and that healthcare planning was poor in one in five cases.

181. Access to therapeutic treatment for young people convicted of a sexual offence is limited, particularly for young people in custody. Few young people who have been convicted of a sexual offence have access to the assessment and/or treatment services they need while in custody and there are no accredited sex offender treatment programmes for young people. As a consequence, some young people are released into the community without having had their risk assessed or addressed. Their chances of being approved for release at parole hearings are affected by the lack of programmes to address young people's risk rather than an absence of willingness on their part to address their behaviour. YOT inspections found that, from start to end of sentence, only

10% of young people recorded within MAPPA had their level of risk reduced.

182. YOT inspections found that few young people who commit offences had formal statements of educational need but many were not receiving appropriate levels of educational provision. Significant numbers were excluded either on a fixed term or permanent basis from statutory education. There were also concerns about the extent to which the needs of children with learning difficulties in the criminal justice system are catered for. YOT inspections show that 14% of children in the criminal justice system have learning difficulties. Of those in custody the figure rises to 28%. Inspections indicate that YOTs identified and addressed these needs. Despite this, in HM Inspectorate of Prisons surveys of young people, 29% of girls and 34% of boys felt they needed help with reading, writing and maths. One youth offending institution was noteworthy for the good attention it paid to young people with attention deficit hyperactivity disorder, but this appears to be an exception.

Children in secure settings

183. Some children and young people who commit serious offences are remanded in custody or sentenced to custody, either in a youth offending institution or to local authority secure children's homes or secure training centres (figure 5). At any one time there are around 2,700 children in secure settings, but the annual turnover is around 7,000 since many of them serve short sentences or are on remand.

Figure 5: Number of young people in the secure estate for children and young people on 1 January each year between 2005 and 2008

	2005	2006	2007	2008
YOI (15–17)	1,922	1,880	2,013	1,899
Secure children's home	111	105	102	104
Secure training centre	136	155	206	186
Private YOI	269	302	300	376
18 y/olds in YOIs	348	362	298	252

Source: YJB 2008, cited in Hansard for the House of Lords, 28 January–1 February 2008.

184. The second *Safeguarding children* (2005) report raised concerns about the welfare of children and young people in these establishments, especially about the use of certain behaviour management techniques. These included the use of physical control, strip-searching and single separation in all settings. The recommendation made in the report about physical control (see below) has not yet been implemented, although the Government has commissioned an independent review of this area (see Appendix A, recommendation 4), and concerns continue to arise from inspections.

> **'The [then] Department for Education and Skills, the Department of Health, the Youth Justice Board and the National Offender Management Service should:** issue one agreed set of principles for the use of control methods in all settings where children are cared for, including secure settings. This should take account of children's views and the need to place the use of physical control within an overall behavioural management strategy and in a wider context of prevention. Arrangements should be made for comprehensive accredited and/or approved training for staff.' [*Safeguarding children: the second joint chief inspectors' report on arrangements to safeguard children;* paragraph 3.4]

Children in local authority secure children's homes

185. Young people may be placed in local authority secure children's homes where there are serious concerns about their welfare and as an alternative to custody or where there are risks that they may cause harm to themselves or others. The demand for places often exceeds the availability and provision overall is reducing. Ofsted inspected 20 secure children's homes which were operating between April and December 2007. All were judged to be adequate or better. The most common requirements for improvement were in behaviour management (15%), the management of medicines (10%) and awareness of child protection procedures (10%). Requirements for improvement in behaviour management normally related to the inadequate recording of incidents of restraint rather than to concerns about the knowledge and implementation of methods of restraint. The adequacy and supervision of staff remain areas for concern, particularly given the complex needs of this group of young people.

Children and young people in secure training centres

186. There are four secure training centres in England providing 301 places for young people. They house increasing numbers of young people who have committed serious, often violent, offences. Inspections found that three of the four secure training centres provide a service that is geared to the needs of the young people housed there. Despite evidence of improvements since previous inspections, the fourth centre was judged to be inadequate overall and had particular problems with behaviour management and control.

187. Inspections found that the admissions process is generally sensitive to the needs of children and young people. Initial health assessments are carried out on arrival followed by a comprehensive screening, which identifies substance misuse and mental health needs. The needs of young people identified as at risk of suicide and self-harm are planned for and regularly monitored. Three of the four centres offer a safe and secure environment for young people to live in and they focus on providing high-quality, child-centred care. Building design problems at the fourth centre, where living spaces are cramped, contribute to behaviour and control problems. Advocacy arrangements and complaints procedures are well-established in all centres.

188. Centres have revised their child protection procedures in line with *Working together* and there are good links between the centres and local children's services. Staff at one centre raised concerns that child protection referrals can take several days to arrive at the local authority. At another centre, the safeguarding team leader was concerned that she is not always made aware of the outcome of management investigations into incidents that are not judged to be child protection matters.

189. Recruitment and vetting processes were found to be thorough and stringent in three out of the four centres. Centres have also made considerable investment in training for staff to ensure they have the skills to work with challenging young people. Nonetheless, recruitment and retention of staff have been problematic for at least two of the centres. There has been a high turnover of staff at these centres and some newly appointed staff have left shortly after completing their initial training.

190. Inquests were conducted recently into the deaths of two young people, Gareth Myatt and Adam Rickwood, in two secure training centres. Gareth Myatt, aged 15, died in hospital on 19 April 2004, following a restraint incident. His death revealed a number of shortcomings in relation to physical control in care, the approved method of restraint in secure training centres. Later that year, on 9 August 2004, Adam Rickwood, aged 14 years, committed suicide in another secure training centre. The inquest found that an incident of restraint had not contributed to his death and that staff had acted appropriately. However, a number of safeguarding issues were identified, including the training of staff in management of suicide and self-harming behaviours. The Coroner made a number of recommendations to Government to improve safeguarding arrangements and review the use of restraint. The Government response, published in March 2008, included the commissioning of an independent review of the use of restraint on young people in youth offender institutions and secure training centres (see paragraph 206).

191. The authorised means of restraint for maintaining good order and discipline in secure training centres is 'physical control in care' (PCC). In three out of the four centres there is a downward trend in the use of PCC and training has focused on reducing the use of restraint and finding alternative ways of addressing challenging behaviour. However, the recording of incidents of restraint did not make the reason for restraint clear in every case. The use of single separation of young people is also decreasing. In addition, one centre has put considerable effort into developing an anti-bullying strategy.

192. The maintenance of order and control was judged to be adequate or better in three out of the four centres. The joint Ofsted/HM Inspectorate of Prisons inspection of the fourth centre confirmed that staff continue to struggle to control the young people in their care. Single separation was used appropriately to prevent young people from harming themselves or others or seriously damaging property. However, there was little monitoring of the reasons for single separation and whether it was being used consistently and fairly. The scale of the centre's difficulties was most starkly illustrated by the very high levels of use of force by staff. In the nine months before the inspection force had been used 757 times and 47% of children and young people surveyed said they had been restrained more than once. Monitoring and analysis of the use of force were very detailed but the centre was unable

readily to produce information on the number of occasions when injuries had occurred during restraint. The centre has started to develop initiatives to improve behaviour management but these have yet to have an effect.

193. Inspections judged that three out of the four centres need to do more to prepare young people for independence and found that accommodation was a particular preoccupation for young people. One centre has established a resettlement planning procedure commencing at the initial planning meeting when a young person arrives.

Children and young people in prison

194. HM Inspectorate of Prisons surveys show that one in five boys and one in four girls did not feel safe on their first night in custody. Furthermore, 31% of boys felt unsafe at some time in their current establishment, as did 25% of girls. Seventy-eight per cent of girls said they had problems when they first arrived in prison, compared with 67% of boys who answered this question. The problems listed include: drug and alcohol dependency; loss of property; housing problems; contacting family; health problems; needing protection from other young people; and feelings of depression. Overall, 70% of the young people surveyed felt they had problems such as these when they first arrived in prison. Many young people arrive at the prison too late at night to discuss these problems and be properly settled in and for good initial assessments to be carried out. Often, they have spent hours waiting for transport in court cells. For example, in one month in one establishment 114 young people arrived after 19.00. In another establishment it was not unusual for young people to arrive after 21.00. By that time, the dedicated casework staff who carried out important reception and first night procedures, including initial assessments, had gone off duty. Essential information such as Asset (see paragraph 314), vulnerability assessments and pre- and post-court reports does not always accompany the young person to help inform initial assessments.

195. Transport arrangements are often poor. Young people still travel with adult offenders on long and distressing journeys. One in 10 boys and one in six girls said they had spent more than four hours travelling in prison vans. Only half of young people said they felt safe during the journey. Many have to travel long distances from the area where they are sentenced and are placed long distances from their home area. In one establishment 41% of young people were more than 100 miles from home. Girls especially are frequently placed long distances from their home area since there are only four dedicated girls' units in England. Inspections of YOTs and prisons raised distance from home as a concern and highlighted its adverse effects on family relationships, while JARs showed that where young people are placed outside their area planning for and monitoring of them are weak. Investigations into the deaths of two children in prison in 2005 included evidence of their distress at being placed a long distance from their home areas and families.

196. HM Inspectorate of Prisons inspections found that collaboration between youth offender institutions and YOTs has improved since 2005. There is usually good attendance by YOT staff at training planning meetings, but when young people are placed long distances from their home area YOT workers can experience difficulties in attending meetings. YOT inspections show that, at the point of sentence one in four young people are not asked about their capacity to cope, which means that their vulnerability cannot be adequately assessed. YOTs could only evidence effective communication with secure establishments in two out of three cases. This fell to 50% of cases where vulnerability or safeguarding issues were present.

197. Some prison officers act as personal officers or key workers for individual young people. They have an important role to play in listening to young people and helping them with their difficulties and concerns. They should provide an appropriate adult role model and generally be involved in all aspects of care planning for the young people they are responsible for. The second *Safeguarding children* (2005) report found that this function was seriously underdeveloped. With some exceptions it remains so.

198. There is good key working in the smaller girls' units. Also, in some establishments, small, dedicated casework teams offer good support to young people. This works best when there is clarity about their role as distinct from the personal officer role and there is good collaboration between the two. In establishments where there is a lack of collaboration the combination of caseworkers and personal officers does not always add value to the overall support of young people.

199. Only 41% of boys and 44% of girls said they had met their personal officer within the first week. Personal officers frequently do not attend important meetings with young people, such as training planning meetings or reviews for those being monitored for self-harm concerns. Furthermore, personal officers do not regularly visit young people who are temporarily segregated in the care and separation unit. An investigation into the death of a young person in a youth offending institution in 2005 highlighted the lack of good support from a dedicated personal officer. Fewer than half the young people surveyed in prisons who had personal officers felt they had helped them. On average, 30% of boys and 47% of girls said that staff had checked on them personally in the last week. Varying comments from young people demonstrated the importance they placed on staff making efforts to talk to them and listen to them.

'During the first few days a screw came and made me feel safe, and listened to my problems.'

'I would like staff to talk to me more, and for my personal officer to talk to me.'

200. Prison inspection reports continue to criticise the use of adult models of control which have not been adapted to suit the needs of children and young people and the failure of the HMPS properly to balance security with the welfare of vulnerable, troubled and troublesome children and young people held in prisons. Although there is a specific Prison Service Order for the care and management of children and young people, there are still many other Prison Service Orders and Prison Service Instructions developed for adults relating to maintaining security and discipline which are also applied to children and young people.[68] These approaches are not easily reconciled with a model of key working and individual case management and care planning for young people.

201. Despite the concerns expressed in the second *Safeguarding children* (2005) report, routine strip-searches still take place, sometimes using force. HM Inspectorate of Prisons' view is that strip-searching should occur only when a risk assessment shows that it is necessary to ensure the safety of the young person or others, and only if other methods of searching would not be adequate to meet safety and security concerns. This procedure is invasive and potentially traumatic, especially for children and young people who have previously been abused, sometimes sexually. However, strip-searching takes place routinely as part of the reception and discharge process, randomly before and after visits, as part of mandatory drug testing and as part of routine cell searches. Many girls in custody have previously been sexually abused but are still subjected to routine strip-searches. In one establishment five of the 14 girls held there had a recorded history of sexual abuse. In the same establishment, one girl who was transferred there from a secure training centre was strip-searched when she left the secure training centre under secure escort and again when she arrived at the prison to comply with routine security requirements.

202. Each prison holding children is required to develop, review and maintain a local security policy that conforms to the Prison Service National Security Framework, which is based on the management of adult prisoners. There is no further guidance and this inevitably results in variable practice, as highlighted frequently in inspection reports. Some establishments have, commendably, adapted the National Security Framework to develop their own risk-assessed model in certain circumstances, such as for cell searches and visits. However, there is no requirement to report each occasion when a strip-search is carried out and prison safeguarding committees do not oversee the practice. Thus there are no figures, by establishment or nationally, on the number that take place each year. Consequently, no evidence exists to support the need to use this procedure for the security of establishments holding children and young people.

203. The consequences of carrying out strip-searching using force on a child who refuses to comply can be particularly damaging, especially for children who have suffered any kind of abuse by adults. Temporary separation with close supervision is, therefore, a viable alternative until the child's agreement to the search has been secured or the risk of harm has been reduced. Establishments do not keep records of strip-searching under restraint and very few require the governor's authority to use force to carry out a strip-search so it is not possible to determine how often it takes place. In one establishment inspectors found two examples of children being strip-searched under restraint and having their clothes cut off.

204. The use of force is the most extreme method of controlling children who have temporarily lost self-control and should be used only when there is an immediate risk to the safety of the child or others, always as a last resort and when there are no viable alternatives. Difficulties frequently arise because there are rarely other well-developed, viable options or alternative agreed strategies within prisons holding children. There are very few properly managed 'cooling off/time out' facilities that operate as part of an agreed strategy of behaviour management. HM Inspectorate of Prisons inspections have found that very few youth offender institutions comply with the YJB's Code of Practice for Behaviour Management and staff training in managing conflict is limited.

205. Youth offender institutions still sometimes use special cells for young people who have lost control. These are inappropriate for children and are not conducive to assisting them to regain control. Children at risk of self-harm are sometimes placed in special cells and sometimes put into anti-ligature clothing (special clothing that cannot be torn easily to make ligatures). This is not an acceptable substitute for proper monitoring and individual care for children at risk of self-harm. Monitoring of the use of anti-ligature clothing is often inadequate and safeguarding committees do not oversee the use of this extreme procedure.

206. Despite the recommendation in the previous *Safeguarding children* (2005) report, little has changed with regard to the different methods of restraint which are still used in different settings. The independent review into the use of physical restraint on young people in youth offender institutions and secure training centres, announced in 2007, has been extended to cover the network of local authority secure children's homes to take account of the wide range of restraint methods used in these settings (see paragraph 190). It is scheduled for publication in September 2008.

207. Young people often complain of inappropriate handling or rough treatment by staff during restraint and inevitably young people are hurt during a pain compliant method of restraint. HM Inspectorate of Prisons surveys showed that 27% of boys reported that they had been physically restrained. There were wide variations between establishments: between 49% at one establishment and 15% at another. Nineteen per cent of girls said they had been restrained. In one establishment there were three recorded cases of broken bones following restraint. In addition, the use of force can also reinforce the belief among troubled young people that violence and physical coercion are acceptable forms of behaviour.

208. Care and separation units are intended to be used for short-term punishments or temporarily to remove a troublesome young person from the residential unit. However, most care and separation units still operate as traditional adult segregation units and the emphasis is on separation rather than care. The young people located in such units rarely have individual care plans, although one establishment inspected was commendably in the process of introducing therapeutic crisis intervention in the segregation unit. Cells in care and separation units are often in poor condition. Girls' units do not operate care and separation units and young women who need to be separated are managed in their cells.

209. Formal discipline hearings known as adjudications that are orientated to adult prisoners have undergone significant procedural changes to make them more age appropriate in many establishments, but they remain overly formal in some and are over-used in general. In one establishment there had been over 1,400 formal adjudications in six months. By contrast, one girls' unit inspected did not use adjudications at all. There is little use of mediation or restorative justice in youth offender institutions.

210. Methods of restraint and all behaviour management procedures for all children in prisons need to be reconsidered. This is particularly the case for the management of children with severe mental health problems, learning difficulties and/or disabilities, attention deficit hyperactivity disorder, autism, personality disorders or a history of abuse. These are all commonly present in youth offender institutions. More needs to be done to determine how good-quality individual care can be provided for a population of challenging young people with very diverse needs within the constraints of a prison environment.

211. JARs found that continuing education and healthcare arrangements for young people leaving secure establishments range from good to inadequate. Prisons inspections show that not all young people leave prison with their accommodation needs organised prior to their discharge. The lack of good personal officer schemes undermines good transition planning and personal officers

rarely attend community reviews. The Children and Young Persons Bill contains a provision aimed at improving transition arrangements for transfer back into the community for those children and young people who are looked after or who were immediately before entering the secure establishment or prison.

Children using health services

212. The Government published the National Service Framework (NSF) for Children, Young People and Maternity Services in September 2004. It is a 10-year programme for sustained improvement in children's health and well-being and an integral part of the Every Child Matters agenda. The NSF sets 11 national standards for children's health and social care. The Healthcare Commission assesses NHS trusts' performance against *Standards for better health* but also considers how well the NHS is applying some of the standards in children's health.[69] Core standard 2 specifically relates to safeguarding children and young people. In 2006–07, 95% of trusts (377) declared compliance with that standard. Four trusts declared non-compliance for the second year running and required follow-up by their Strategic Health Authority.

213. In 2006, the Healthcare Commission published a review of 157 NHS and foundation hospital trusts assessing progress against key requirements of the hospital standard (standard 7) of the NSF.[70] These include the treatment of children in child-specific and child-friendly environments, the provision of sufficient numbers of staff trained in the care of children, and the organisation of services to ensure that staff maintain their skills in treating children. Twenty-five per cent of trusts received an overall score of excellent or good, but 70% scored fair and needed to make a range of improvements. Areas of concern were raised by five per cent of trusts scored as weak, which did not meet a significant number of standards.

214. The needs of children are better met when they are cared for in child-only services. Trusts had made considerable progress in ensuring that children were admitted to child-only wards, with 99% meeting this standard. This level of achievement did not extend to other services such as A&E (38%) and outpatients' departments (46%). Some boards of trusts were still not recognising children's care as a matter for the board or for the trust as a whole. Furthermore, some trusts in the review found difficulties in identifying all the services used by children, all the staff working with children and their level of training.

215. Staff coming into contact with children need appropriate training and should work with enough children every year to maintain their skills in treating them. In most trusts appropriate arrangements were in place. However, in 8% of trusts surgeons did not carry out enough work with children to maintain their skills to carry out surgery on very young children. In addition, 16% of paediatric inpatient units carried out less work with children than the recommended minimum professional level. The review also raised concerns about the levels of cover for emergency care and surgery, especially out of hours. Research by the Confidential Enquiry into Maternal and Child Health also shows that some health services are still not ensuring that staff assessing children have sufficient paediatric training to recognise serious illness and refer appropriately. In some cases, poor communication between health professionals has meant that important mental health problems or chronic illness have not been recognised soon enough for effective treatment to be put in place.[71]

216. Progress in communicating with children and providing staff who specialise in play was poor. Many children had a poorer experience in hospital than they should have had. Only 24% of nurses and 7–9% of surgeons and anaesthetists were formally trained in communicating with children. The review also raised concerns about child protection and, in particular, whether staff always know how to identify and refer children at risk, reflecting concerns expressed in the second *Safeguarding children* (2005) report. In any one service where children are treated 95% of nurses should be trained in child protection, but 58% of services reviewed did not meet this standard.

217. The Healthcare Commission is continuing to follow up the findings from the review and to promote improvement in the safeguarding elements of trusts' work. Data submitted by trusts on these areas will form part of the 2007–08 annual health check.

Children with learning difficulties and/or disabilities

218. Children and young people with learning difficulties and/or disabilities have variable levels of complexity of needs. Some of them may suffer from several different conditions and require ongoing therapeutic and other treatment. They are often more vulnerable to bullying in care and education settings. Where they are also looked after it is particularly important that any concerns are quickly identified and addressed.

219. JARs found that the integration and coordination of service provision are improving in nearly all areas. Agencies are working together better and there are good examples of multi-agency teams with staff from health, education and social care services. Early needs identification for very young children is mostly very good and multi-agency assessment has improved. However, services are inadequately coordinated in some areas, especially for older children and young people. The use of the lead professional role is critical to the effective coordination of services but in some areas this role has been slow to develop. However, where the lead professional role is established, there are examples of staff from health, education and social care services taking it on. In a few areas parents are also encouraged to take on the role.

Examples of innovative work by and for children and young people with learning difficulties and/or disabilities

In Rotherham, young people with learning difficulties and/or disabilities have set up their own consultation group, Orchard Flyers, to discuss issues about short term breaks and respite. This has enabled some of them to develop their communication skills and confidence and has led to some undertaking accredited training to become children's rights representatives.

Local young people with hearing impairment in Greenwich have produced an excellent book of poetry, *Life and deaf*. This reflects the good work being done to enable them to participate as citizens in Greenwich.

220. Services normally support children with the most complex needs well but high thresholds restrict access to services for children with moderate levels of learning difficulty and/or disability in many areas. There is particularly limited service provision in specialist therapeutic and respite services (despite increased provision of the latter), speech and language therapy, CAMHS and special equipment. Limited capacity in therapeutic or respite services often leads to a high dependency on out-of-area placements to meet complex needs. The National Service Framework for Children, Young People and Maternity Services requires provision of CAMHS for children with learning difficulties and/or disabilities to be an essential component of a comprehensive CAMHS. At 31 January 2006 just under 3% of areas had CAMHS in place for children and young people with learning difficulties and/or disabilities. This increased to 18% in 2007 but widespread shortfalls in service provision remain. Service provision for children with attention deficit hyperactivity disorder or autism is particularly variable.

221. Education provision for children with learning difficulties and/or disabilities is overall adequate or better. Multi-agency arrangements are helping to support more children and young people in mainstream schools. Early identification of children is very good overall and nearly all have access to good early years services which work effectively with both primary and specialist schools to smooth the transition into full-time education. Transition arrangements to support children and young people moving between schools work successfully overall and include parents and carers effectively in the planning. Arrangements for young people moving into further education or employment are less consistent. In some areas, transition planning is not fully embedded and hindered by ineffective joint working arrangements with adult social care and health services. Furthermore, choice of further education and employment is limited for most young people with learning difficulties and/or disabilities by a lack of provision of education, training or employment placements that can cater for their needs.

222. Achieving the participation of children and young people in the planning of services and consultation varies greatly between areas. In some areas children with learning difficulties and/or disabilities do not have access to advocacy services. Those who are resident in children's homes are frequently invited to contribute to the design and delivery of their services, but an audit

by the Healthcare Commission shows that young people in specialist units had very little involvement in the design of their environment.[72] Some dedicated facilities were unsuitable for young people and institutional in appearance. The Healthcare Commission's audit focused mainly on services for adults but it raised concerns about adolescents with learning difficulties who were accommodated in adult facilities.

223. In regulated care settings, safeguarding was found to be adequate or better. Residential special schools' overall current compliance with national minimum standards has improved considerably since the introduction of national minimum standards in 2002–03.[73] However, significant areas for improvement remain, including health, safety and security (75% met or exceeded the NMS in 2006–07); vetting of staff and visitors (74%); and staff supervision and support (77%).

Asylum-seeking children

224. Following concerns raised in the first *Safeguarding children* (2002) report about their experiences, the second report (2005) included a chapter on children seeking asylum, drawing on targeted inspection work. The report acknowledged that providing services for asylum-seeking children is a challenging and complex task, affected by factors outside the control of individual agencies. The local authorities inspected for that review were committed to safeguarding these children and there were examples of good dedicated services. However, services for unaccompanied asylum-seeking children aged 16–18 and support for over-18s not previously in care were inconsistent. The report also raised substantial concerns about the welfare of children held with their families in immigration removal centres.

225. The UK Border Agency is responsible for managing immigration to the UK.[74] The UK is a signatory to the 1951 United Nations Convention Relating to the Status of Refugees, which requires that protection be given to refugees fleeing persecution in their home countries. The UK also adheres to the European Convention on Human Rights. If a person does not qualify for asylum, but there are humanitarian or other reasons why he or she should be allowed to stay in the UK, temporary leave to remain may be granted.[75]

226. The Government is a signatory to the United Nations Convention on the Rights of the Child 1989 but it has a reservation for the purposes of immigration control. The second *Safeguarding children* (2005) report commented on this. In January 2008, the Home Secretary announced a review of, and accompanying consultation on, this reservation with a view to determining whether it should be withdrawn. In addition, the UK Border Agency has consulted on a proposed *Code of practice for keeping children safe from harm*.[76] The code will cover children arriving with their families as well as unaccompanied asylum-seeking children. It will require UK Border Agency staff to be responsive to the needs of children while they are being dealt with in the immigration system and sets out the procedures UK Border Agency staff should follow when dealing with children. The UK Border Agency has also recently announced plans for improving support to unaccompanied asylum-seeking children and trafficked children claiming asylum by locating them with specialist local authorities. These authorities will assess and meet their needs for support and protection while the UK Border Agency resolves their immigration status.[77]

227. Many children and young people arrive with their families or relatives to seek asylum in the UK. Others arrive unaccompanied. In 2006, there were 23,610 applications for asylum in total, a decrease of 8% from 2005.[78] Most asylum seekers, including unaccompanied asylum-seeking children, arrive in the south of England, either at airports near London or at south coast ports. Where asylum-seeking families arrive without accommodation or the means to support themselves, they may qualify for support. Government policy has been to disperse families from London and the south east where accommodation is very limited to other areas of the country. In 2006 the top three dispersal towns in England were Leeds, Birmingham and Manchester.

228. Where children arrive with adults, it is not easy to detect private fostering arrangements or identify victims of human trafficking and sexual exploitation. In recent years there has been a growing recognition of these problems among relevant agencies and several initiatives to tackle them. These include dedicated police operations to rescue and protect victims of trafficking and to identify and bring to justice those responsible. In addition, the UK Human Trafficking Centre was set up in 2006, bringing together staff of the police service, CPS, Serious Organised Crime Agency, Border and Immigration Agency (now the UK Border Agency) and social services. It acts as a centre for the development of expertise and the coordination of activity to tackle trafficking.

229. In 2006, 3,245 applications for asylum were from unaccompanied asylum-seeking children aged 17 or under. The top five countries of origin were Afghanistan (30%), Iran (10%), Eritrea (10%), Somalia (8%) and China (8%). Unaccompanied asylum-seeking children are normally the responsibility of the local authority with social services in the area where they arrive. These children and young people are particularly vulnerable and may have been subject to torture, inhuman treatment or sexual exploitation in their country of origin. They pose particular difficulties in determining their correct age where they arrive without adequate documents, although there are now fewer age dispute cases in detention. Following a high court case in February 2006 the Border and Immigration Agency issued new guidance to give the benefit of the doubt to asylum seekers in age dispute cases. Many children and young people face an uncertain situation while awaiting the outcome of their asylum application and living in local authority care.

230. The Local Government Information Unit (LGIU) estimates that there are 120,000 refugee and asylum-seeking children in the UK, including 80,000 in schools. There are around 3,300 asylum-seeking children looked after by local authorities.[79] The number of asylum-seeking children looked after by local authorities varies considerably. However, the highest numbers are in Croydon, Hillingdon, Manchester, Birmingham and Solihull, which are all close to some of the main entry points into the country. In some authorities, unaccompanied refugees and asylum seekers account for a significant proportion of the total number of looked after children, particularly in areas such as Croydon and Solihull.

231. JARs found that there are some good targeted services to cater for the needs of asylum-seeking children, including health and CAMHS. These are particularly important since children may have specific physical and mental health needs associated with deprivation, repression and conflict in their home country. It is often difficult to ascertain their previous medical history, especially their immunisation status, and they may suffer from previously undetected medical conditions such as HIV, hepatitis and tuberculosis. However, the best authorities had carried out work directly with young people to develop a more effective approach to providing health assessments and treatment or counselling services.

Example of work to support asylum seekers

A well-established youth service project in Leicestershire provides particularly good information, specialist guidance and peer support to young refugees and asylum seekers. The project has achieved national recognition for its excellent practice.

232. The quality of provision for asylum-seeking children who are looked after is more variable than for other looked after children in the same area. Their options for accommodation are often more limited and asylum-seeking children are frequently placed outside their host areas. Where this occurs, social care services also comply less well with care planning requirements than for other looked after children. As with all placements, this increases the risk of poor support and safeguarding, especially for those in out-of-area placements. There is also evidence that some councils are still not adhering to the Hillingdon judgement and are inappropriately using section 17 of the Children Act 1989 to provide limited support, such as temporary accommodation, instead of providing care and accommodation for looked after children under section 20.[80]

233. The Hillingdon judgement confirmed that unaccompanied asylum-seeking children who have been in care are also eligible to receive appropriate leaving care support post-18. The DCSF provides a retrospective grant to help local authorities meet the leaving care costs for unaccompanied asylum-seeking children. Local authorities that have provided support to more than 25 eligible children leaving care during the financial year 2007–08 may apply for the grant.[81] In some areas, JARs found that compliance with requirements for leaving care was lower for unaccompanied asylum-seeking children than for other care leavers in the same area.

234. Short-term holding facilities are used to hold children who are arriving or being removed with their families or unaccompanied asylum-seeking children pending their transition to local authority care (see paragraph 38). Detainees are held for many hours and sometimes overnight in facilities that are neither designed nor appropriate for that purpose. There are no separate, child-appropriate facilities, except for unaccompanied children, even though families could be held for more

than 24 hours. Arrangements for the protection and care of children are inadequate in all the short-term holding facilities. At Heathrow, the airport where the majority of families are held, inspectors found that the summary copy of child protection procedures on display did not address the specific circumstances of this group of children. Staff were not trained in child protection and had only a limited understanding of child protection procedures. There was no contact with the LSCB and the local authority manager responsible for unaccompanied asylum-seeking children was unaware that children could be held on site for over 24 hours. The LSCB was unaware of the fact that children were held there. Statistics produced by the UK Border Agency do not include the number of children who have been held.

235. Under immigration law, the UK Border Agency can detain people whose applications are under consideration or whom it plans to remove from the country, including asylum seekers. They are held in immigration removal centres. Unaccompanied asylum-seeking children are not normally held but children may be detained as part of a family group. There are two immigration removal centres in England that can accommodate families with children. One is the UK Border Agency's main immigration removal centre for women and families and the other has a small family unit but it is not intended to hold families for more than 72 hours. An immigration removal centre in Scotland is outside the scope of this review. Ministerial approval is required to detain children beyond 28 days in an immigration removal centre.

236. The second *Safeguarding* report expressed substantial concerns about the welfare of detained children and made recommendations to the Government to improve the priority given to safeguarding them. Although recent initiatives to improve support for asylum-seeking children are welcome, it is nonetheless disappointing that the Government rejected these recommendations as unnecessary (see recommendation 10, Appendix A). Reinspections of both immigration removal centres in England since 2005 have noted improvements in aspects of their safeguarding practice, but have raised continuing concerns about the welfare of the children detained.

237. Large numbers of children were still being detained at both centres. At the longer stay centre, numbers had reduced since 2005, but greater numbers were being held beyond 28 days. During the period May to October 2007, 450 children were recorded at that centre, of whom 83 were held beyond 28 days. (This included a period of chicken-pox quarantine which may have extended the length of stay for some.) The longest single period of detention recorded was 103 days but there were some very lengthy periods of cumulative detention, the longest being 275 days.[82] In the short stay centre, 411 children had been held over an 11-month period. Centre records showed that a number of children had been detained beyond 72 hours and three children had been held for over 28 days, having been transferred from the other centre after spending a similar period there. Inspectors were not convinced that children were held exceptionally and for the shortest possible time, and this exposed the limitations of the centre for detaining children at all.

238. At both centres, there had been significant improvements in relationships with local social services and in the handling of childcare cases. All staff at both centres had received enhanced CRB checks. Both centres had well-established links with the local LSCB. Representatives from social services attended quarterly child welfare group meetings, which included key staff from child protection agencies. There was regular telephone conferencing with the Border and Immigration Agency (now the UK Border Agency) and weekly welfare meetings reviewed the cases of all detained children in detail. An on-site social worker at the centre holding children for the longest periods produced welfare assessments, which were submitted as part of the process to decide whether to detain children further. The other centre, which generally held children for much shorter periods, did not have an on-site social worker but had improved links with a local team specialising in children seeking asylum so that welfare assessments could be carried out if necessary. However, these assessments were carried out only after a period of 21 days. Inspectors considered that this was too long to hold children in detention without an assessment of their needs or a review of the impact of detention on their welfare, and that seven days was more appropriate. None of the children had individual care plans.

239. There was no evidence that the needs of individual children were taken into account when initial decisions to detain families were taken. Documentation or information that would enable staff to identify concerns about children frequently did not accompany them to the detention centre. At one centre there were two cases of children with special needs who should not have been admitted since the centre was not adapted to their needs. Inspectors also raised continuing concerns about the

way in which families and children were initially taken into detention and transported. There were examples of very long journeys, without sufficient comfort breaks, in inappropriate escort vans with caged compartments.

240. Inspectors carried out nine interviews of children with their parents at a centre. All the children reported feeling scared, upset or worried on arrival. Parents indicated that children who had been doing well in the community became withdrawn in detention, had difficulty eating and sleeping, or showed a pattern of deteriorating behaviour. These were regular themes and grounds for concern at the weekly welfare meetings.

241. There was still a lack of child healthcare expertise in the short-term centre. Health services in the longer-stay centre had shortcomings in the following areas:

- lack of child-friendly facilities
- no registered sick children's nurse (although the centre was attempting to recruit one)
- no counselling services for children and young people
- no arrangements for assessing mental health needs or access route to mental health beds
- no contact with the local community mental health team or CAMHS.

242. There had been limited progress at either centre in providing education for children since the previous inspections and teaching staff concentrated on the adult population. Children had inadequate access to outside recreational areas during detention. In the shorter stay centre there was no attempt to offer children any educational guidance or support. At the other centre, the range of ages and abilities in the two classes provided was very wide. Teachers were unable to spend sufficient time with individual children and there were no learning support assistants to help them do so. Despite good efforts by teaching staff, some school-aged children did not attend education.

Children from minority ethnic groups

243. In children's services there is increasing awareness of the varying needs of children from different minority ethnic groups. There are specific services and increased provision for individual groups, including support for immigrants from Eastern Europe, whose numbers have increased significantly in recent years, and for children from travelling communities. There is also evidence of the increasing involvement of community and faith groups in the planning of services and in their representation on LSCBs. Youth services support young people from minority ethnic groups well in most areas.

244. All local authority areas have carried out a Race Equality Impact Assessment on all services, including children's services. However, in some areas there is limited monitoring of the effects of safeguarding activity on incidents of harm or abuse of children and young people from minority ethnic groups. The proportion of these children who have a child protection plan remains lower than their overall proportion in the national population. The proportions of those with a child protection plan who are of mixed ethnic origin or who are Asian or Asian British have increased slightly between 2004–05 and 2006–07 (figure 6). Audits of need within and across areas do not always reflect the diversity of need. In some areas assessments of the needs of individual children and young people sometimes fail to address specific needs relating to ethnicity.

Figure 6: Percentage of children from minority ethnic groups subject to a child protection plan

	2004–05	2006–07
Children of mixed ethnic origin (%)	6.9	7.2
Children who are Asian or Asian British (%)	4.2	5.2
Children who are Black or Black British (%)	5.3	5.2

Source: DCSF 2007.

245. Young people from black and minority ethnic groups have been, and continue to be, over-represented in the criminal justice system in England, although the YJB has noted slight reductions between 2005–06 and 2006–07. They are predominantly clustered in areas within big cities that have higher proportions of people from black and minority ethnic groups than rural areas. In 2006–07 these children and young people were over-represented in relation to the total population in 74% (96) of YOT areas in England. In 25% of areas they were over-represented by more than 5%. London accounted for two thirds of areas where children and young people from black and minority ethnic groups were over-represented by more

than 5%. YOTs are aware of this situation and work to identify and tackle the issues. All YOTs carried out a race audit in 2005–06. This contributed to action planning and the YJB monitors the outcomes.

246. The extent to which other criminal justice agencies are alert to and respond to the needs of children and young people from black and minority ethnic groups varies. For example, for the majority of CPS Areas, there is clear evidence of links with different minority ethnic groups. This varies depending on the practice and demographic make up of the individual areas. Engagement with all children and young people is generally through schools and the citizenship programme on an information-giving basis.

247. All youth offender institutions are required to have in place a race equality action plan and Race Equality Action Teams to ensure that the plan is implemented. This includes overseeing the handling of racial complaints, monitoring data, promoting good race relations, and collating and disseminating good practice. Race Equality Action Teams operate efficiently overall and some establishments involve young people in them. There is less involvement of local race equality councils or community groups. Good ethnic monitoring exists in most establishments to highlight areas of potential discrimination, but concerns are not always followed through and properly resolved.

248. Despite the existence of Race Equality Action Teams, prison inspections show that establishments generally make insufficient efforts to promote diversity and race equality. Surveys of young people in 14 establishments show that young people from black and minority ethnic groups believe they have a worse experience of prison than their white counterparts in some aspects of their care. The most common themes they raise are respect from staff, control and restraint, and complaints handling. These are particularly important factors in promoting feelings of being safe. Work with young people who are foreign nationals is generally underdeveloped. However, some establishments have made good efforts to organise peer support and ensure that young people who are foreign nationals receive their basic entitlements.

Children and young people and the armed forces

249. Children and young people under 18 may be dependants of a service family or may themselves be in the armed services as recruits or trainees. Where children are dependants, their family may experience frequent moves, either overseas or between bases and garrisons in the UK. This makes it very important that services authorities are aware of any concerns about safeguarding or promoting the welfare of these children.

250. Where children of armed forces personnel are in the UK, local authorities have a statutory responsibility for safeguarding them and promoting their welfare. The armed services are represented on LSCBs in 19 areas where there is a significant concentration of service personnel. However, their involvement was described as operational rather than strategic in the LSCB survey. Children of armed services families are not covered separately in local children and young people's plans for the areas where they live.

251. When service families are based overseas, the Ministry of Defence (MoD) has responsibility for safeguarding and promoting the welfare of their children. The MoD funds the British Forces Social Work Services (Overseas), which is contracted to the Soldiers' Sailors' and Airmen's Families Association (SSAFA). In four countries where there are large concentrations of forces personnel – Germany, Cyprus, Gibraltar and Brunei – there are staffed overseas social work teams. In these cases, overseas LSCBs are in place. Numbers of children on the child protection register remain relatively stable, usually between 30 and 40, although this is proportionately higher than for the England population overall. There are also between five and 10 looked after children from the United Kingdom placed with forces families overseas.

252. Overseas forces families and their children may experience particular difficulties. These can include displacement from their culture and community, the absence of a serving parent, trauma arising from action, domestic violence and alcohol abuse. The social work overseas services operate lower thresholds than those applied in most areas in England and focus on earlier intervention and preventive services in response to these difficulties.

253. Improvements are still needed in several aspects of service. Some overseas command units do not have a social work presence and arrangements for safeguarding children are not clear. There is no clear process for overseas command units to notify the Secretary of State for Children, Schools and Families of serious incidents in accordance with Chapter 8 of *Working together to safeguard children* and child death review processes are not yet in place. The military and SSAFA acknowledge that the development of a clear MAPPA procedure, which is not currently in place, is a priority. Furthermore, there is a lack of consistency in inspection arrangements for services for children. They exist for schools, early years and the SSAFA Forces Help Adoption Agency, but there is currently no process for inspecting either safeguarding arrangements overall or the SSAFA Forces Help Fostering Service.

254. Between 2004 and 2007 the Adult Learning Inspectorate (ALI) carried out inspections of military establishments providing training for new recruits and trainees.[83] ALI's first report in 2005, *Safer training*, showed that training and care of young people undergoing training were not sufficiently well-managed. A second report, *Better training*, published in 2007, showed that military training establishments had made significant improvements. Notable achievements included integrating welfare and risk management into initial training. This included:

- welfare registers for all recruits, overseen by senior staff; these ensure that young people are identified who are at risk due to family bereavement, injury or illness, failure in training or self-harm
- better arrangements for managing under-18s, including involving parents where appropriate and more closely supervising recruits, especially at night and at weekends
- a proactive approach to reducing harassment, bullying and inappropriate behaviour towards young recruits.

255. The MoD has done much to improve staff awareness of the different needs of new recruits aged under 18 joining the armed services. 'Supervisory care' directives that are specific to individual establishments set out how new recruits should be supported. These directives are reinforced by comprehensive training and individual needs-based risk assessments which are regularly reviewed and updated. In the best examples senior staff are kept informed of progress of those most at risk.

256. General support services for recruits under 18 are well-organised, highly effective and integrated with the military chain of command. They provide an extra level of support. Other voluntary services deliver a valuable and much appreciated service to many serving personnel. Their position outside the formal chain of command allows them to provide an alternative perspective and a less formal service than military welfare staff.

Conclusions

257. Inspections have identified improvements in the safeguarding of **looked after children and care leavers** since 2005. These include better planning of placements in care and greater stability of placements, a reduction in out-of-area placements; more effective health monitoring, and increasing allocation of children to named and qualified social workers. Inspection has found that all aspects of children's care, health and education have to be addressed well to ensure good outcomes for each individual child. However, many children are still not well served and improvements are needed in the following areas:

- One in 10 children's homes and fostering services are judged to be inadequate in keeping the children in their care safe. Inspections highlight the lack of experienced and competent staff and insufficient compliance with requirements for the supervision of staff.
- The choice of placement remains limited for most children and some children feel it is hard to influence decisions that involve them.
- Rates of educational attainment and school attendance remain unacceptably lower for looked after children than for other children.
- Children and young people in most areas continue to experience frequent changes of social worker. The lack of continuity has an adverse effect on the quality and progress of their care plans.
- Some looked after children and young people who go into custody subsequently have less contact with their allocated social worker than required or expected; this was the case in one in six YOT areas inspected. This is a particular problem where children are in custody a long distance from their home area.
- Social workers in prisons have provided support to looked after children and young people and have started to liaise well with other services. The

uncertainty about continued funding for these posts significantly constrains their future development.

- There is a lack of suitable accommodation for care leavers and young people leaving custody in most local authority areas.

258. Organisations are working together better to identify **children and young people who go missing** from home, care or education and to deal with the underlying causes when they run away. However, no single agency has responsibility for maintaining reliable statistics on the numbers of children involved and information about the scale of the problem is fragmented and inconsistently collected.

259. Recognition of the needs of **young carers** has increased in children's services and in schools, and support for them to attend school and leisure services has improved. However, processes for identifying young carers are underdeveloped which makes it difficult to plan capacity to meet the potential demand for services.

260. Since 2005, attention to safeguarding at a strategic level within Cafcass has increased but has yet to make sufficient impact on front-line practice. Cafcass has made progress in increasing the participation of children and in strengthening the voice of **children in family justice proceedings**. However, the quality of front-line practice in two Cafcass regions has recently been judged to be inadequate, posing potential risks to some children.

261. Improvements in witness care have benefited **children who attend court as victims and witnesses** and the courts treat child witnesses with care and sensitivity. However, inspections found that there is little systematic consideration by YOTs and probation services of the specific needs of children as victims.

262. Youth specialists in the CPS normally prosecute the cases of **children and young people who have committed an offence** and their handling of these cases is mostly satisfactory. Inspections also found many examples of good practice in YOTs' direct work with children and young people who offend. However:

- inspections raise continuing concerns about the length of time young people spend in court custody facilities before being transported to a secure setting
- assessments by YOTs of the needs of young people who offend often lack rigour and are not informed by home visits from social workers in a significant minority of cases
- concerns remain about the adequacy of health services for children and young people who offend, who are more likely to have physical and mental health needs than other children
- access to therapeutic treatment for young people convicted of a sexual offence is limited, particularly for young people in custody
- access to and sustaining of both statutory education and post-16 education, training and employment for children and young people who offend are inconsistent
- the needs of children and young people with learning difficulties who offend are not well identified or catered for.

263. Inspections have reported improvements since 2005 in arrangements for safeguarding **children and young people in secure settings**. These include more robust child protection procedures, better communication between YOTs and youth offender institutions, and the introduction of social workers in youth offender institutions. Nonetheless, considerable concerns remain about the welfare of young people in these settings:

- The recommendation from the second *Safeguarding children* (2005) report concerning the use of restraint on children and young people has not been implemented. Restraint techniques currently in use still vary between different types of setting and some rely on pain compliance.
- Other security and disciplinary measures applied to children and young people in youth offender institutions, including routine strip-searching without sufficient assessment of risk, are based on the risks posed by adult prisoners and do not take sufficient account of the specific vulnerabilities of children.
- Children placed in secure settings at long distances from their homes are less well monitored than those placed within their home local authority area.

264. Most NHS trusts (95%) comply with the National Service Framework core standard for safeguarding **children and young people who use health services**. The majority of hospital trusts admit children to child-only wards and nearly all have made progress in providing child-friendly environments, appropriate security and play areas. Concerns remain in the following areas:

- the lack of priority given to children's safeguarding by some NHS trust and PCT boards
- the extent to which staff receive training in child protection
- the maintenance of skills in treating children by specialists including surgeons and anaesthetists.

265. Agencies are working together better to provide services across health, education and social care for **children with learning difficulties and/or disabilities.** Early needs identification for very young children is mostly good and multi-agency assessment has improved. However, access is limited to specialist therapeutic and respite services, speech and language therapy, CAMHS, special equipment, and services for children with attention deficit hyperactivity disorder or autism.

266. Since the previous *Safeguarding children* (2005) report, there is greater recognition of the support and safeguarding needs of **asylum-seeking children**, especially those who arrive unaccompanied. Nationally, this is demonstrated by recent policy developments that aim to improve support. Locally, inspections have found good, targeted services in the community, especially in health and CAMHS. Concerns remain that:

- arrangements for the protection and care of children in short-term holding facilities at airports are inadequate
- a few local authorities provide less support to looked after children and care leavers who are unaccompanied asylum-seekers than they do to other looked after children and care leavers in their area.

267. The two immigration removal centres in England that accommodate **asylum-seeking families with children** have made significant improvements in working relationships with local social services and in the handling of childcare cases. Despite this, there are continuing concerns about the effects of detention in immigration removal centres on children's well-being and about delays in carrying out welfare assessments of these children. The Government did not accept the associated recommendations made in the previous *Safeguarding children* (2005) report. However, in the light of recent inspection findings, they are repeated in this report.

268. There is increasing recognition by local services of the varying needs of **children from minority ethnic groups**. A range of services is available for specific groups and there is increasing involvement of community and faith groups in planning services. However:

- in some areas, assessments of the needs of individual children and young people sometimes fail to address specific needs relating to ethnicity
- surveys show that young people from minority ethnic groups feel that they have a worse experience of prison than young people who are white.

269. In the larger armed forces command units overseas, there are overseas social work teams and LSCBs to safeguard **children of armed forces families**. Inspection arrangements exist for schools and adoption services overseas. However, there is currently no overall inspection of how children of armed forces personnel overseas are kept safe or of the fostering service available.

270. Inspections of military establishments providing training for **young armed services recruits** show that the management of their safeguarding and welfare has improved considerably since 2005.

Recommendations

Local authorities

- Local authorities should make adequate provision of safe, sustainable and supported accommodation and stop the use of bed and breakfast accommodation for care leavers and young people both at risk of custodial remand or returning to communities from custodial settings.

Government

- The DCSF and the Home Office should monitor at a national level the incidence of children missing from home.
- The DCSF and the YJB should provide guidance to staff working in custodial and residential settings on the behaviour management of children and young people. Such guidance should include a model behaviour management strategy and emphasise that restraint should only be used as a last resort and should not be used solely to gain compliance. The guidance should make clear that methods of restraint should not rely on pain compliance.

- The DCSF and the YJB should issue a requirement that all incidences when restraint is used in custodial settings and which result in an injury to a young person are notified to, and monitored and publicly reported by, the LSCB.
- The DCSF and the YJB should issue a requirement that all incidents of strip-searching of young people in custodial settings are risk assessed and recorded and that this data should be monitored by prison safeguarding committees. The YJB should monitor the aggregated data nationally across the secure estate.
- The DCSF and the Ministry of Justice/YJB should provide long term funding for social work input into youth offender institutions.
- The DCSF, DH and the YJB should make the necessary provision to ensure that all children who display, or are convicted of, sexually harmful behaviours are assessed and their needs for treatment are met.
- The DCSF, the DH and the Ministry of Justice/ YJB should ensure continuity in the provision of mainstream services, particularly health and education, when young people return from a secure setting into the community.
- The UK Border Agency should ensure that children are detained only in exceptional circumstances and for no more than a few days. The individual welfare needs of children should be taken into account, and that process documented, in any decision to detain and throughout the detention process.
- The DCSF should issue guidance to local councils to ensure that children whose detention continues for more than **seven** days are subject to an independent welfare assessment of their health, welfare, educational and developmental needs and have an individual care plan. The welfare assessment and care plan should inform weekly reviews of the continued detention of children.[84]

Introduction

271. Effective child protection is a fundamental part of safeguarding children and young people. Children's social care services have a statutory duty 'to safeguard and promote the welfare of children in their area who are in need and, so far as it is consistent with that duty, to promote the upbringing of such children by their families'.[85] They also have a duty to make enquiries if they have reason to suspect that a child in their area is suffering, or likely to suffer, significant harm. This is to enable them to decide whether they should take action to safeguard or promote the child's welfare. While different agencies such as social services and the police have distinct roles in child protection, all agencies who provide services to children and young people have a responsibility to respond to concerns where children or young people may be at risk of harm.

272. The report of the Victoria Climbié inquiry found that a range of agencies had failed in their duty to protect Victoria. There was a series of systemic failings that urgently needed to be addressed to avoid similar situations occurring in the future.[86] The first *Safeguarding children* (2002) report also found that attention to safeguarding in general and child protection in particular was in need of considerable improvement. These reports helped to inform the *Every Child Matters* Green Paper and the subsequent Children Act 2004, which established more robust systems for identifying and acting in partnership on welfare concerns.

273. The second *Safeguarding children* (2005) report noted that agencies were working together better and there was greater clarity about roles and responsibilities. However, there remained significant concerns about the ability of staff in some agencies to recognise the signs of abuse or neglect, the application of inappropriately high thresholds by certain social services departments in their child protection and family support work, and the capacity of local authorities to respond to all the children and families needing support.

274. Since 2005, the provisions of the Children Act 2004 have come fully into force. These include the integration of children's services, the establishment of LSCBs with guidance to focus on making their child protection work effective, and a new CAF to assist agencies in identifying welfare needs and revised arrangements for sharing information. The Government has also provided revised and updated guidance for agencies working with children. This chapter considers what has changed since 2005 and assesses how well these revised arrangements are working.

Compliance with *Working together to safeguard children*

275. *Working together to safeguard children 2006* (hereafter referred to as *Working together*) provides a national framework within which agencies work individually and together to safeguard and promote the welfare of children.[87] The Government revised the guidance in 2006 to take account of changes introduced by the Children Act 2004, particularly the establishment of LSCBs. The revised version also reflects changes to safeguarding practice in recent years, especially in the light of the Victoria Climbié and Bichard inquiries.[88,89]

276. JARs have found that nearly all areas have revised their child protection procedures in line with the new guidance. This includes strengthening procedures for the management of allegations against staff. Some LSCBs have collaborated to produce joint procedures to increase consistency in child protection work across local authority boundaries. However, in some areas, procedures lack sufficient practice guidance for staff. There are also gaps relating to particularly vulnerable children such as those with learning difficulties and/or disabilities and compliance with the Bichard recommendations.

277. JARs have also found that access to procedures and provision of guidance to staff are generally good across agencies. Most agencies have improved staff awareness of child protection responsibilities in nearly all areas. Designated members of staff are in place across most agencies. Schools have very good compliance in appointing designated child protection teachers. However, some areas report difficulties in recruiting designated doctors for child protection work.

278. Other inspection work reinforces the evidence about improved guidance and access. HM Inspectorate of Constabulary's programmed inspections of police forces in 2007 assessed the investigation of child abuse. In 2005 ACPO issued comprehensive national guidance on investigating child abuse and safeguarding children, compatible with *Working together*. Inspections found

that the *Working together* arrangements were well incorporated into force policies and procedures. Where inspections identified gaps, they related primarily to staffing and workload issues in individual forces or basic command units (BCUs). In particular, where cases were initially assessed as low risk, under-resourcing could lead to decisions about whether or not to carry out a criminal investigation being based on the availability of staff as opposed to established criteria. This resulted in such cases being passed to social care services for a single-agency response, with little or no active police involvement. Breakdowns in process in this area of work can, therefore, be underlying symptoms of resourcing difficulties. Few areas for improvement in staffing or process were identified in the best performing forces. In addition, these forces demonstrated the following common features: robust internal scrutiny arrangements, for example of the quality of investigations and compliance with criteria for investigations; the auditing of recording practices; and the active use of performance management information to drive improvement.

279. Despite the evidence of progress, inspections continue to raise concerns that some practitioners show less understanding of child protection and welfare needs than others. The second *Safeguarding children* (2005) report included evidence that not all NHS staff working with children knew how to recognise the signs of abuse or neglect. The Healthcare Commission's review of hospital services for children, published in 2007, showed that not all staff in NHS trusts had received basic child protection training.[90] There were particular shortfalls in training in services where staff should be trained to intermediate level, such as A&E and inpatient services. It is particularly important that staff in those services know how to recognise the signs and symptoms of abuse and can draw the attention of designated child protection staff to any signs of concern.

280. Cafcass plays an important role in safeguarding children's welfare in family court proceedings. This includes identifying children who might be at risk. Recent inspections of Cafcass regions have been highly critical of aspects of practice. Cafcass introduced an overarching child protection policy in 2004 and updated child protection procedures in 2007 as part of its Safeguarding Framework. Despite these initiatives, inspectors found considerable variation in front-line practice and raised serious concerns in the East Midlands region about inadequate practice, particularly in private law work. This included failure to make a referral to the local authority about identified child protection concerns. Similar findings were reported in Cafcass South East region and give grounds for concern that front-line child protection practice is not sufficiently robust.

281. Some CPS Areas have appointed specialists and champions for child abuse but their remit depends mainly on individual Area practice and those involved, as there is no central guidance for the role. The role of specialists and co-ordinators nationally is being reviewed in 2008. The CPS has established national networks to act as links between headquarters and CPS Areas for youth, rape and domestic violence related offences. However, there is no similar network for child abuse. There has been no national, overarching guidance for practitioners on child abuse, information having been until recently contained piecemeal within other procedural guidance. This situation resulted from the removal of out-of-date information and delay in introducing revised guidance. The gap has been partially filled by the recently issued safeguarding children guidance on victims and witnesses, which adopts the three key principles of expedition, sensitivity and fairness, although more comprehensive information on child abuse should be issued shortly. There is no central collation of information on child abuse cases; arrangements for the sharing of information between child abuse specialists and the analysis of casework are dependent on individual area practices and a policy-led practitioners group with restricted membership.

282. Inspectors found that child abuse cases were not allocated to CPS child abuse specialists in all cases. Nonetheless, child abuse cases were mostly satisfactorily handled. In 98% of cases the advice or initial review complied with the Code for Crown Prosecutors on both evidential and public interest grounds and in 96% of cases the charge reflected the seriousness of the offence. Shortcomings noted included inadequate guidance to prosecuting advocates with instructions, insufficient consideration of victims' views when discontinuing a case, and lack of proper handling of sensitive material. In addition, some files inspected had not been endorsed to show that the prosecution lawyer had reviewed child witness video evidence where it was available. The second *Safeguarding children* (2005) report also identified this as an area needing improvement.

283. In YOTs, children and young people dealt with often have a history of abuse or are judged as being at risk or

in need. Inspections found that compliance with child protection procedures was generally good or better. In spite of this, there were a small number of cases where child protection referrals should have been made but had not been adequately identified before the inspection itself. The YJB provides limited guidance on YOTs' statutory obligations and there is no 'best practice' guidance in relation to vulnerability and safeguarding.

284. The establishment of safeguarding managers in all youth offender institutions with YJB funding has helped to improve the management and overall understanding of child protection and wider safeguarding. It has resulted in a significant shift from practice that was mainly reactive and concentrated on child protection to a more proactive welfare approach based on a broader interpretation of safeguarding. Youth offender institutions, child protection policies are based on prescriptive guidance and a template issued by the HMPS as part of a Prison Service Order, which is compatible with *Working together*. However, some policies are little more than a reproduced template that has not been adapted to the local setting.[91] There is better attendance of local authority representatives at safeguarding committee meetings in prisons and some have worked with the youth offender institutions in the development of their child protection and safeguarding policies. Disclosure of historic abuse is common and generally well-managed, partly as a result of social workers now being established within youth offender institutions. They are well placed to liaise with child protection agencies from the young person's home area.

285. Despite these improvements, inspectors raised continuing concerns about areas of policy and practice within youth offender institutions. There is inconsistency about what constitutes a child protection referral and therefore the threshold for referral to the local authority. Very few referrals are considered to reach the threshold for a section 47 investigation. Most establishments refer allegations arising from the use of force to the local authority for investigation as a child protection concern. The threshold for investigation into what local authorities see as a legitimate procedure in a prison appears to be higher than in other settings where children make allegations about adults caring for them. Consequently, local social care services frequently make a recommendation that the youth offender institutions should carry out an internal investigation. Such investigations are frequently limited to the legitimacy of the procedure and inspectors came across examples where investigations had not been carried out as recommended. Guidelines to prisons about internal investigations are based on an adult Prison Service Order and consequently do not mention or include child protection considerations. New national procedures, whereby all allegations against adults who work with or care for children and young people are referred to local authority designated officers, are yet to be tested with regard to youth offender institutions.

286. Few youth offending institution policies contain detailed guidance on whistle-blowing that ensures that staff know they have a duty to report ill-treatment by other staff, how to do so and that they will be protected from reprisals. This is especially important within a closed institution. In addition, the quality of management information about child protection varies from excellent to very poor. Some establishments do not collect and analyse numbers and types of child protection referrals at all while others produce detailed trend analysis for the safeguarding committee. Safeguarding committees rarely have an oversight of reports of unexplained injuries. Injuries arising from the use of force are not consistently monitored for patterns or trends. With a few noteworthy exceptions, the use of force is not usually part of the safeguarding agenda but is instead regarded as a separate security issue.

Serious case reviews

287. An important part of the *Working together* guidance is the conduct of serious case reviews. Serious case reviews should be carried out when a child dies (including by suicide) and abuse or neglect are known or suspected to be a factor in the death. They can also be undertaken where the case raises particular welfare concerns. Examples include where a child has sustained a potentially life-threatening injury through abuse or neglect.

288. Where a case arises, the LSCB should establish a serious case review panel, involving at least the local authority children's service, health, education and the police. The panel decides whether the case should be the subject of a serious case review, applying criteria set down in *Working together*. Each service involved conducts an individual management review of its practices to identify any changes that should be made. The LSCB also

commissions an overview report from an independent person, which brings together and analyses the findings of the individual management reports and makes recommendations.

289. The responsibility for receiving notifications of serious incidents involving children and for evaluating the quality of serious case reviews transferred from the Commission for Social Care Inspection (CSCI) to Ofsted in April 2007. The DCSF, in partnership with Ofsted, has developed a new national child protection database for recording all notifications and information on serious case reviews. Local authorities are required to notify Ofsted of all incidents involving children that are serious enough that they may lead to a serious case review, including where a child has died or suffered significant harm as a result of abuse or neglect, or that raise concerns about professional practice, or that have attracted national media attention. Between 1 April 2007 and 31 March 2008, 281 serious incidents were recorded, which related to 189 deaths, 87 incidents of significant harm or injuries and five incidents where the outcome for the child was not known, for example where a child was reported to be missing following a serious incident. The spread of notified serious incidents across Government Office regions is set out in Figure 7. This shows a substantial variation which is attributable in the greater part to inconsistent reporting practices across local authorities.

Figure 7: Notifications of serious incidents by local authorities between 1 April 2007 and 31 March 2008

Government Office region	Death of child or young person	Serious incident involving child or young person	Other
North West	38	18	1
Yorkshire & The Humber	34	13	1
South East	28	9	2
North East	19	11	
London	21	9	
East	12	8	1
West Midlands	16	4	
South West	10	9	
East Midlands	11	6	
Total	**189**	**87**	**5**

Source: Ofsted.

290. The profile of the children and young people who are the subjects of the serious incidents is set out in Figure 8. Of particular note is the high proportion (41%) of babies under the age of one year who died or suffered significant injuries or harm.

Figure 8: Profile of children who were subjects of notifications of serious incidents between 1 April 2007 and 31 March 2008

	Percentage
Gender	
Male	44%
Female	56%
Age	
0–1 year	41%
1–3 years	13%
4–5 years	5%
6–9 years	8%
10–13 years	9%
14–17 years	22%
Unknown	2%

Source: Ofsted.

291. The Government Office regions provide guidance to LSCBs on carrying out serious case reviews. The DCSF has responsibility for publishing biennial reports on lessons emerging from serious case reviews, but has not yet published the report for 2005–07.[92] As part of its new responsibilities, Ofsted has introduced a more transparent and consistent process for evaluating serious case reviews. This assesses the extent to which the review fulfilled its purpose by reviewing the involvement of agencies, the rigour of analysis and the capacity for ensuring that the lessons identified are learned. The evaluation process aims to support the improvement of practice and safeguarding at a local and national level by ensuring that outcomes of all evaluations are notified to LSCBs, Directors of Children's Services and the DCSF. A report on the evaluations carried out since 1 April 2007 is scheduled to be published in July 2008.

292. The Prisons and Probation Ombudsman has responsibility for investigating the deaths of children in HMPS custody. Serious case reviews are also carried out in these circumstances. Although the Ombudsman and serious case review investigators make contact with each other, there is no guidance setting out how they should be coordinated.

293. There are considerable variations between LSCBs

in the number of serious case reviews they have carried out. Ofsted's survey of 118 LSCBs in 2007 showed that around a quarter had not carried out any at all compared with the 5% that had completed five or more (figure 9). While there are bound to be some variations, owing to the differing numbers of serious incidents and deaths of children and young people between local authority areas, they do not fully account for the extent of the discrepancy. It is also partly due to inconsistent interpretation by LSCBs of the guidance in *Working together*. Some LSCBs that had not carried out any serious case reviews had used alternative methods, including individual management reviews or case file audits. One area with no serious case reviews had four 'lessons learned' reviews in progress. Comments emerged from the survey about resource implications, potential media interest and the lack of a 'critical incident culture' in one area affecting the number of serious case reviews commissioned.

Figure 9: Frequency of serious case reviews (SCR) carried out by LSCBs between 1 April 2006 and 1 October 2007

Number of SCRs	% of LSCBs
0	24%
1	31%
2	24%
3	12%
4	4%
5	3%
6	1%
7	1%

Source: Ofsted survey of LSCBs 2007.

294. There are serious delays in the production of serious case reviews in most cases. They should normally be completed within four months of the decision to carry one out but nearly all take much longer. This is unavoidable where criminal cases are conducted simultaneously and there are associated *sub judice* issues. However, there is evidence that some of the delays are avoidable and the agencies involved have not given them sufficient priority.

295. The quality of serious case review reports varies considerably, including both overview and individual management reports. Since 1 April 2007, Ofsted has received 36 serious case reviews. Of those, 12 (33%) were judged good, 15 (42%) adequate and nine (25%) inadequate. The main characteristics of those that have been conducted well include:

- open and critical review of agency involvement
- clear analysis of actions
- well-constructed action plans to support lessons learned
- SMART[93] recommendations for future action.

296. Of those judged inadequate, significant weaknesses include:

- vague or over-general terms of reference
- failures to identify or address gaps in information
- lack of rigour in challenging shortcomings in practice
- insufficient focus on the child
- inadequate critical analysis of the involvement of partner agencies
- failure to secure the cooperation of partner agencies in three cases, including a mental health trust, another local authority and the coroner
- insufficient clarity about the lessons learned
- action plans unsupported by monitoring to ensure their implementation.

297. The results of Ofsted's evaluation of serious case reviews and the 2007 survey of LSCBs raise issues about the involvement and commitment of other agencies. Some services have issued guidance about involvement in serious case reviews, for example the CPS in its guidance on LSCBs and ACPO in its guidance on the investigation of child abuse cases and safeguarding children. However, there is evidence of a lack of priority given to serious case reviews by some local authorities and LSCBs have failed to secure cooperation from all relevant agencies in a few cases. Inspections of police forces also noted variability in the quality of individual management reports. In addition, the Healthcare Commission's audit of LSCBs raised doubts about whether trusts contributed effectively.[94] These related specifically to delays in producing individual management reviews and lack of monitoring of action plans.

298. Lessons learned from serious case reviews highlight the importance of sharing information and communication, accurate chronologies of events, clarity of planning and roles, overcoming the problems of hard to reach or potentially more resistant families, and the quality of assessment. Early recognition of children

in need of protection by mainstream services such as schools or health services is identified a frequent failure. Several also highlight difficulties in communication and the planning of intervention between adult or mental health services and core teams implementing child protection plans.

299. Several LSCBs have commissioned work to analyse and share the lessons from serious case reviews going back over a number of years (see examples below). In addition to contributing to two serious case reviews, the Healthcare Commission has worked with a former strategic health authority and the Commission for Social Care Inspection to review five serious case reviews where common themes emerged about professional practice relating to children in healthcare organisations.[95] These included shortcomings in the assessment of children's needs, failure to act on safeguarding concerns and poor communication between agencies and professionals.

Examples of LSCB work to share the lessons from serious case reviews

Croydon LSCB audited serious case review outcomes for the past four years to ensure that all actions had been carried through. It commissioned full executive summaries and has integrated the findings into training. The Corporate Parenting Panel has received summaries of serious case reviews to gain greater understanding of the issues.

Somerset LSCB completed a 10-year study of serious case reviews undertaken since 1995 and has identified domestic violence and parents with substance misuse problems as thematic issues for further work.

Schools in West Berkshire submit an annual report to their governing bodies (copied to the LSCB) on safeguarding.

300. Many LSCBs plan to make further changes to their serious case review arrangements to introduce greater rigour and objectivity. This includes the use of external or independent chairs of case review panels, the use of external expertise on individual management reviews and independent authors for overview reports.

Identification, assessment and management of children at risk or in need

301. The point at which concerns are first raised about a child is critical in achieving an appropriate response and a positive outcome. All those working with children should be able to identify children at risk of significant harm or those who are in need because of their vulnerability.[96] Despite the guidance available in this field, the second *Safeguarding children* (2005) report raised concerns that not all staff in all agencies providing services to children were equipped to do this. It also noted that most social services departments were applying inappropriately high thresholds and that lack of staff capacity meant that children and families in need might not be receiving the services they needed.

302. The numbers of referrals to children's services reduced between 2005 and 2007 but this masks significant variation between areas. JARs show that children's services in most areas have established clearer thresholds for accessing services since the second *Safeguarding children* (2005) report. This meets the requirement of *Working together* in paragraph 3.18, which requires LSCBs to clarify the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention. There is evidence of increased consistency in some areas in the application of thresholds in cases of neglect. This has resulted in earlier identification and increased registrations of children on the child protection register under the category of neglect.

303. However, in some areas thresholds for referring children to social care services remain high and a good understanding of thresholds across all agencies, while improving, is not yet fully established. This results in a lack of equitable access to services for children and young people in need. For example, some YOTs reported experiencing variable and frequently shifting thresholds for carrying out children in need assessments in social care, which they often described as resource-led.

304. JARs judged responses to referrals of child concerns to be safe and appropriate in nearly all areas. Arrangements in most local authority children's social care services for monitoring responses to referrals are robust. This has improved since the second *Safeguarding children* (2005) report. Front-line duty and assessment teams in children's services are generally well-managed

and links with health service staff are reinforced in many areas by placing a health visitor on each duty team. There has been an increase in the number of referrals leading to initial assessments, which indicates that clarity about thresholds is improving. Initial assessments are completed nationally within timescales in 68% of cases, and core assessments in 78% of cases, but both figures conceal considerable variation between authorities. The quality of assessments varies between outstanding and inadequate. Where there is good practice, assessments are timely; carried out in partnership with the child, family and relevant agencies; address holistic needs; provide a rigorous analysis of the available information; and properly consider the views of the child and parents or carer. Section 47 investigations into allegations of abuse or neglect are timely in most areas.[97] However, following interventions, some cases are closed without the necessary, or effective, communication with partner agencies.

305. There has been a slight increase in the numbers of children subject to a child protection plan (CPP), but re-registrations have not increased. The proportion of children subject to a CPP for more than two years has fallen slightly (figure 10).

Figure 10: Children subject to a CPP 2004–05 to 2006–07

	2004–05	2006–07
Number of children subject to a CPP	25,900	27,900
Child Protection Registrations per 10,000 population aged under 18	27.7	30.1
Numbers of children subject to a CPP per 10,000 population aged under 18	23.4	25.2
Re-registrations on the CPR per 10,000 population aged under 18	13.4	13.4
CPPs that were discontinued per 10,000 population aged under 18	28.1	28.8
Percentage of CPPs ceasing that had a duration of at least two years	6.0	5.8

Source: DCSF; the figures for numbers of children are rounded.

306. JARs have found that child protection plans are mostly of good quality and relevant and core groups that meet regularly support their implementation. Compliance with timescales for reviews of children subject to child protection plans has improved and nearly all take account of the views of children and parents. Independent chairing of reviews is helping to ensure the effective delivery of child protection plans. The allocation of child protection cases was nearly 100% in almost all areas, which is a considerable improvement on the findings of the second *Safeguarding children* (2005) report. There is generally good compliance with social worker visiting requirements, particularly for seeing children alone.

307. There is increasing provision of more effective earlier intervention services, which are targeted appropriately in areas of greater need. New and good services have also been developed to combat sexual exploitation. In addition, services to prevent family breakdown are reducing the numbers of looked after children. There has also been an increase in the allocation to social workers of children in need cases in some areas. However, preventive services are not well coordinated in some areas and access to these services is particularly difficult for children and young people and their families in rural areas.

308. Concerns remain about the identification and management of children and young people in the criminal justice system who might be at risk or in need. Young people who commit offences are often among the most vulnerable children in the community. YOT inspections found that 2% of children in YOTs and 3% of those in custody are on the CPR, which is higher than average. In the community 18% of children and young people who offend were assessed as a risk to themselves while 16% were at risk from others (family and peers). In custody these figures rise to 37% at risk of self-harm and 35% at risk from others.

309. YOTs have good child protection and safeguarding policies and procedures in place and there are many examples of effective inter-agency outcomes-focused work. However, policies are sometimes applied inconsistently. Home visiting only forms part of the assessment process in two thirds of all YOT and probation cases and there is a lack of consistent communication with parents and carers. Vulnerability plans do not exist in many cases and where they do, they do not always reflect the actual levels of vulnerability or the actions taken. Inspections revealed that one in five of all pre-sentence reports by YOTs were poor in assessing vulnerability and one in five probation cases were

insufficient in assessing safeguarding issues. In addition, 37% of probation risk assessments were insufficient in risk management planning for victim safety.

310. In terms of outcomes, YOT inspections judged that 82% of young people in the community who offend and who were assessed as at risk were the subjects of appropriate action. While this is commendable, it does mean that one in five assessed as at risk did not receive an adequate response. Of those at risk of harm in custody, inspections judged that 91% had received appropriate action from YOTs. When surveyed during YOT inspections, young people themselves showed less confidence in the interventions they had received.[98] Of those in the community, 14% had felt unsafe and 75% of those said they had received the help they needed to be safe. In custody, 16% had felt unsafe and 70% of those thought they had received appropriate help.

Example of appropriate action by a YOT

The YOT arranged pre- and post-custody Child in Need meetings for a vulnerable and violent young woman who was also pregnant. All relevant professionals attended the meeting and agreed a support package for her and her child. This included psychiatric treatment for her, education at a local PRU, attendance at mother and baby classes and childcare for her baby. Although her attendance at the mother and baby classes was not good, the YOT's parenting worker was involved in giving her support, her attendance at the PRU was said to be good and her behaviour had greatly improved.

311. Staff in youth offender institutions always complete initial vulnerability assessments for each new arrival but their quality is affected by the time of the young person's arrival and the extent of the information which accompanies them. Vulnerability assessments in youth offender institutions are generally not part of a process of continuous review and reassessment and care plans for managing vulnerability are seldom drawn up, even when risks are identified. There are good examples of effective systems to identify the most vulnerable young people and strategy meetings take place in some establishments to plan for the care of the most vulnerable. However, this practice is not consistent throughout youth offender institutions and caters for a small minority of the total youth offending institution population. Strategies for addressing different types of vulnerability rarely exist. Part of the remit of social workers in prisons is to promote the welfare of all children and young people held there and to complete children in need assessments where appropriate. Inspections have identified examples of improved service provision for young people following social worker assessments and the ongoing involvement of social workers in pre-release planning.

Common Assessment Framework and information-sharing

312. The Common Assessment Framework (CAF) for Children and Young People is a shared assessment tool for use across all children's services. It aims to assist the early identification of a child's additional needs and promote coordinated and integrated service provision.[99] It does not replace targeted assessment processes, such as those for children in need or with special educational needs, but is designed for use at an earlier stage before the threshold for multi-agency intervention is met. Directors of children's services, working with partner agencies, are responsible for implementing the arrangements in their area. Key features of CAF are:

- the designation of a lead professional who is responsible for coordinating the actions identified in the assessment process; he or she acts as the main point of contact for children where more than one practitioner is involved
- the effective sharing of relevant information between agencies and practitioners.

313. JARs found that most areas were on target to implement CAF and the Integrated Children's System, which is a case management and practice system for supporting children in need. Good training and project management have supported CAF's implementation. There is growing ownership of the lead professional role, especially in schools, and other agencies are increasingly involved in CAF arrangements, although their involvement still varies considerably. Many areas were less confident about implementing ContactPoint (formerly known as the Information-sharing Index), which will make basic information about all children and young people up to 18 in England available to authorised staff across agencies.

The main concerns of children consulted by the Children's Rights Director about the planned database were about the information held being incorrect or not held securely enough to prevent unauthorised access.[100] These concerns partly contributed to the Government's decision in June 2007 to postpone the implementation of ContactPoint pending a review of its security.

314. Acceptance of responsibility for completing assessments by staff in agencies other than social care varies considerably. Community health centres, schools and children's centres are making most progress. In some places there is also a perceived blurring of the distinctions between the assessment processes for children in need and those for children in need of protection. This has resulted in delays in recognising child protection issues. Also, assessment processes in other services, such as Asset in YOTs, which were developed separately, have not been updated to align with CAF.[101] The lack of alignment does not promote effective communication or information-sharing when assessing a child's eligibility for a range of targeted or specialist services. It is also a potential barrier to the effective operation of the Integrated Children's System.

315. Information-sharing between agencies is improving, although this is usually at operational level. Agencies such as the police and social services have well-established protocols and procedures for sharing information. For example, there is a model joint protocol produced by the CPS for the exchange of information between the police, CPS and local authorities during the prosecution of child abuse cases. Many criminal justice areas have adopted this or a local model, but some local authorities have declined to formalise arrangements.

316. Health information is less effectively shared, despite respect among health practitioners for the ethos of information-sharing between professionals. Inspectors also noted this in YOT inspections. This is partly because good practice in healthcare indicates that consent should be sought from a competent child or parent, which may sometimes conflict with safeguarding issues. The General Medical Council is reviewing its current general guidance on confidentiality.[102]

317. Forthcoming guidance from the YJB aims to improve the sharing of information about young people in the youth justice system and communication between relevant agencies and practitioners. The lack of initial information arriving with young people in youth offender institutions from YOTs remains a problem. However, social workers in prisons are producing some assessments of children in need and some are generating comprehensive data on safeguarding. The uncertainty of future funding for social worker posts in prisons puts this work at risk and may also stifle positive initiatives for information-sharing within youth offender institutions and with other agencies.

Management and accountability

318. The Victoria Climbié inquiry found that a lack of accountability for child protection among senior staff in most of the agencies that dealt with Victoria was a major factor in the failings that led to her death. Since then, the priority given to child protection has increased at senior levels in many agencies.

319. Structural changes to local authority children's services have helped to promote safeguarding and child protection across a wide range of services. Management oversight and supervision have improved in local authority children's services and front-line management is generally good. Front-line staff are better supported and have access to good quality supervision in most areas. Clear monitoring and case file auditing processes are in place, which is an improvement on the findings of the two previous *Safeguarding children* reports. This is leading to improvements in the consistency and quality of practice.

320. The implementation of workforce strategies in children's services has helped to reduce vacant posts and the numbers of social workers leaving posts overall. This masks variations in social work resources, which are limited in some areas, and the retention of skilled and experienced staff remains a problem. This results in lack of continuity for children and young people and delays in transferring cases between teams. There is also evidence that it has an impact on the application of referral thresholds in practice.

321. Management oversight and supervision vary considerably in other agencies. Many NHS trusts and PCTs have worked hard to raise the profile of children's services. Despite this, concerns remain about the priority given to children's issues by some NHS trust and PCT boards and independent healthcare providers.

Inspections of Cafcass have criticised the lack of clear accountability for and lack of supervision of front-line practice. In YOTs, there are clear systems of supervision and appraisal of staff and satisfactory spans of control but boards vary in their level of oversight of performance management. There is limited reporting of vulnerability and safeguarding issues to senior management.

322. HM Inspectorate of Constabulary's programmed inspections of police forces found clear links between performance and the effectiveness of accountability frameworks. All forces have identified leads at ACPO level with strategic responsibility for child protection and safeguarding children. The majority of forces operate under a devolved structure with operational and strategic accountability being split between BCUs (operational) and headquarters (strategic/policy). This means in practice that, while strategic and policy direction is maintained centrally, individual BCU Commanders have responsibility for taking decisions about how policy is implemented. Devolution therefore allows for the development of local solutions to tackle local problems. However, previous thematic inspections have identified that, when functions are devolved across BCUs, there is the potential for significant local variations and practices to develop. This can create difficulties for the strategic/policy lead in ensuring that policy is applied corporately across a force and that there is a consistent standard of response and service delivery. To address this, it is essential that forces have in place unambiguous accountability frameworks which clearly define the lines of operational and strategic responsibility at each level from practitioners through to chief officer lead. These need to be supported by effective performance monitoring, clear lines of communication and sound governance.

323. While all forces have accountability frameworks in place, they were not always effectively documented or communicated and some gaps in the chain of accountability were identified at senior management level, most notably at BCU Commander level. These areas for improvement were absent in the better performing police forces. These forces also demonstrated a number of key strengths which reinforce the links between good performance and effective accountability: the linking of accountability with performance management frameworks; effective governance and lines of communication; robust internal scrutiny arrangements (such as regular audit, review or 'health checks' to test compliance with policy and consistency in service delivery); and active monitoring of performance where areas for improvement have been identified. In line with the recommendation from the second *Safeguarding children* (2005) report, ACPO is developing a national performance indicator set for the investigation of child abuse.

324. All youth offender institutions have safeguarding committees to oversee the strategic management of all aspects of safeguarding but some committees lack clear terms of reference. Their size and structure vary considerably, as well as the level of child protection and safeguarding expertise of the membership. There are examples of excellent individual case monitoring of vulnerable young people and child protection referrals within a sound safeguarding committee structure. However, there are also examples of a lack of oversight of child protection by key managers in some establishments and an absence of clear accountability. Management lines vary and safeguarding managers do not always manage all staff with a safeguarding function. There is no system of supervision and support of individual front-line staff by managers within an accountability framework for staff in youth offender institutions. The responsibility of the LSCB for scrutiny of individual practice or overall monitoring has not yet been fully developed in this aspect.

Training

325. *Working together* states that all staff working with children should attend training in safeguarding and promoting the welfare of children. They should also receive regular refresher training. The second *Safeguarding children* (2005) report found that the frequency and quality of training vary considerably. This remains the case, although inspections noted improvements.

326. Much training is taking place that is directly relevant to safeguarding in general and child protection in particular. Many agencies have made a considerable investment in training. Examples include the following:

- JARs found good and well structured training strategies in most local authority areas. There is also multi-agency training covering wider safeguarding, as well as themed child protection practice.
- The CPS has made significant investments in training, including a rolling programme from 2005 to 2008 of domestic violence training developed with the

police for all lawyers and case workers, training for all lawyers and case workers on sexual offences, including a range of new offences such as grooming, and a training package in child abuse developed by a CPS Area, which will be rolled out nationally following piloting.

- ACPO has addressed the training gaps noted by inspections in the police service. Specialist investigators attend an initial crime investigators' development programme. More recently, a specialist child abuse investigation programme developed by the National Policing Improvement Agency has also been introduced.
- Training in YOTs is generally satisfactory or better, with good examples of inter-agency training. Training plans identify safeguarding and child protection training needs across the board for staff.

327. The HMPS has completed the roll-out of its national Juvenile Awareness Staff Programme (JASP), which includes modules on basic child protection awareness and safeguarding. Six out of 14 units inspected had 90% or more of staff trained, including the four smaller girls' units. However, only five out of 14 youth offender institutions had all staff trained, while three out of 14 had significant numbers of staff not trained at all. JASP is a generic programme covering a very broad base about how to work with adolescents in prison. It lacks the benefit of multi-disciplinary training. The programme has not been evaluated but the short modules covering child protection and safeguarding within it are unlikely fully to address the needs of staff in prisons working with some of the most difficult children in the criminal justice system. By contrast, training in secure training centres is more targeted and looks at issues such as autism and special needs.

328. Specialist training for safeguarding children with complex needs is generally good but it is often provided on a single rather than a multi-agency basis. There are some groups of staff that are rarely included in multi-agency training. For example, in some prisons, staff are able to take up offers of multi-agency training from the local authority. However, this is not the norm and some prisons have ceased to make joint training available to staff now that training is available through JASP.

329. There is sometimes an over-emphasis on training courses instead of in-house support for staff development, for example by seconded social workers in YOTs. Electronic learning and self-briefing can be effective learning methods, but this type of training needs to be followed up to determine its impact. Where training issues were identified for police forces, this was one of the commonest areas for improvement.

330. Access to training for certain groups of staff continues to be limited, as noted in the second *Safeguarding children* (2005) report. Reasons for this include workload and staff shortages. Some LSCBs also reported financing difficulties. These groups include staff in schools, youth services and children's homes, GPs, prison staff and some YOTs staff. The Healthcare Commission found that the absence of training for some staff was a significant area of risk for NHS trusts.[103] All trust staff should receive training in basic (level one) child protection training. Recognised good practice is for 95% of nurses in any one service to receive this training, but 58% of services (632) nationally did not achieve this. Nationally, low numbers of hospital specialists including surgeons and anaesthetists had received basic child protection training, although this varied considerably between trusts. Intermediate level (level two) training enables staff working with children to identify the signs of abuse. Good practice is for 95% of nurses in A&E and inpatient services to receive this training, and one nurse on each shift in day case and outpatients should be trained to level two. Only 70% of services (769) achieved this level of training.

331. Where training is well-planned and managed, there are common trends. For example, evidence from HM Inspectorate of Constabulary's programmed inspections in 2007 shows that the better police forces use succession planning to inform training needs, identify mandatory training needs for individual roles, incorporate learning from reviews and audits into training, and take up opportunities for joint training with partners.

Conclusions

332. Nearly all local authority areas have revised their **child protection procedures** in line with new guidance in *Working together.* Some LSCBs have produced joint procedures. Access to procedures and guidance to staff is generally good across agencies. There are still areas for improvement:

- Inspections continue to raise concerns that some practitioners do not have sufficient knowledge and understanding of child protection. They include staff in the NHS who have not received basic or intermediate child protection training, some front-line staff of Cafcass and a few instances in YOTs.
- Child protection in prisons has improved, but there are still areas of concern. These include the thresholds for external investigations and the rigour of internal investigations into allegations arising from the use of force. The recording and monitoring of child protection cases are very variable.
- In just under a third of cases, serious case reviews have been judged to be inadequate because of a lack of rigour in carrying them out. There are also serious delays in producing them in nearly all cases, some of which are avoidable. These factors limit the impact of serious case reviews on sharing the lessons and good practice arising from these cases and on improving practice.

333. Most local authorities have established clearer **thresholds** for access to children's social care services. Arrangements for the management oversight of front-line practice in children's services have also improved. Nearly all local authority child protection services are judged to be satisfactory or better. However:

- there is evidence that thresholds are still not well understood by referring agencies and thresholds are sometimes raised by local authority children's services in response to workload pressures, staffing shortages and limited resources
- the identification and management of children and young people in the criminal justice system who might be at risk or in need of additional support are less well-developed than in social care services; YOTs' pre-sentence reports were poor in assessing vulnerability in one in five cases inspected, while prisons do not assess vulnerability on a continuing basis
- lines of accountability and responsibility for child protection are not clear in all agencies, including some NHS trusts, Cafcass, YOTs, parts of the police service and youth offender institutions.

334. Most areas are making good progress in developing the CAF. **Information-sharing** between agencies on child protection or welfare concerns has improved at an operational level and there are well-established information-sharing protocols between many agencies. However:

- methods for assessing needs relating to safeguarding are not aligned with the national framework for assessment in all agencies; for example, the assessment framework used by YOTs, and the way it is applied, lacks rigour, as do assessment processes in Cafcass
- difficulties persist in parts of the NHS and throughout the youth justice system about sharing sensitive information on the needs of individual children and young people.

335. The provision of **child protection training** for staff across agencies is generally good and many agencies have made considerable investments in training. Despite this:

- some training, such as training for prison staff in juvenile awareness, does not cover child protection issues in sufficient depth
- access to child protection training for some groups of staff is limited; these groups include staff in schools, youth services and children's homes, GPs, prison staff, some YOTs' staff and nurses and hospital specialists.

Recommendations

Government and Local Safeguarding Children Boards

- The DCSF and LSCBs should ensure greater consistency in decision-making about when a serious case review should be commissioned.

Government and inspectorates

- Ofsted should report annually on the outcome of evaluations of serious case reviews.
- The DCSF should ensure that the national dissemination of biennial reports on the lessons learned is timely.

Government

- The DCSF and the YJB should ensure that the assessment tools used within the youth offending service and secure settings are robust in addressing the safeguarding needs of children and young people.
- The DCSF, the DH, the Home Office and the Ministry

of Justice should ensure that information-sharing arrangements between healthcare professionals and other professionals providing services for children are in place and monitored to ensure informed and coordinated service provision.

- The DCSF, supported by other relevant government departments, should provide an annual update of progress made on the recommendations in this report.

All agencies providing services to children and young people

- All agencies that have a statutory duty to cooperate on safeguarding children (local authority children's services, district councils, police, primary care trusts (PCT), NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should clarify the chain of accountability and responsibilities for child protection from the front line through to their most senior level.

A Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

This appendix has been prepared by the Department for Children, Schools and Families and other government departments. It notes the Government's response to the recommendations in the previous (2005) report and summarises the actions taken since then.

The Department for Education and Skills and the Home Office should:

Recommendation	Action
1. Give consideration in national consultation on Local Safeguarding Children Boards (LSCBs) to: ■ developing appropriate links with the full range of agencies working with children in addition to the core agencies on LSCBs. This should include the courts, the Crown Prosecution Service and, where appropriate, the immigration service, including removal centres and local enforcement offices; ■ the management of and dissemination of learning from serious case reviews; and ■ accountability arrangements and responsibility for forward planning between the LSCBs and the children's trust governance arrangements.	Recommendation accepted The revised inter-agency guidance *Working Together to Safeguard Children* was published by HM Government in April 2006, following extensive consultation. Chapter three of this document sets out the roles and responsibilities of LSCBs, including their position within the wider context of children's trust arrangements to improve children's overall well-being. It set out the organisations that should be involved in LSCBs, in addition to the core statutory partners – these include immigration and asylum services, the CPS, local Family Justice Council and the local CJB. Chapter eight of *Working Together to Safeguard Children* includes guidance for LSCBs on carrying out serious case reviews and follow up actions to ensure that lessons are learnt. In addition, the findings of two research reports on child death reviews were published by the Department for Children, Schools and Families on 31 January 2008. They are: *Improving safeguarding practice: study of serious case reviews 2001–2003*; and *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005*. Kevin Brennan wrote to all chairs of LSCBs and directors of children's services on 19 February 2008 to emphasise the importance of acting on the findings. A further overview has been commissioned of serious case reviews in 2005–07.

The Department for Education and Skills should:

Recommendation	Action
2. Review arrangements to safeguard children where they are away from home in settings that are currently unregulated, such as sports, music or language centres etc. to ensure that appropriate regulation and safeguarding arrangements are in place. This review should also apply to armed services settings which accommodate children.	Recommendation rejected This recommendation was rejected as there are already a range of measures in place to safeguard children in settings that are currently unregulated. The fact that a child who has become 16 years of age is living independently or is a member of the armed forces does not change their status or their entitlement to services or protection under the Children Act 1989. Continued...

Continued...	The new Independent Safeguarding Authority (ISA) scheme, developed in response to the Bichard Inquiry recommendations, is due to go live in October 2009. This is the toughest ever vetting and barring scheme and is designed to prevent individuals who are known to pose a risk of harm to children or vulnerable adults from gaining access to them through their work. Under this scheme all those who wish to work with children, whether in a paid or unpaid capacity, will need to register with the ISA before they enter the workforce. In addition, the *Staying safe: action plan* (February 2008) included the commitment to establish a new National Safeguarding Unit for the Third Sector to provide advice and assistance to all third sector organisations on safer recruitment policies, risk management in activity provision and anti-bullying policies.
3. Reinstate the duty on social workers to visit children looked after at a minimum specified frequency and require social services, and subsequently, children's services, to monitor these arrangements effectively.	Recommendation accepted as good practice Clause 13 of the Children and Young Persons Bill, which at the time of writing is before Parliament, provides for local authorities to maintain effective contact with children in care by making explicit the duty for social workers to visit all looked after children, including those placed in children's homes, in supported independent living and those in youth custody. This is included in the Care Matters implementation plan (*Care Matters: Time to Deliver for Children in Care*) published jointly by the Department for Children, Schools and Families, the Association of Directors of Children's Services and the Local Government Association.

The Department for Education and Skills, the Department of Health, the Youth Justice Board and the National Offender Management Service should:

Recommendation	Action
4. Issue one agreed set of principles for the use of control methods in all settings where children are cared for, including secure settings. This should take account of children's views and the need to place the use of physical control within an overall behaviour management strategy and in a wider context of prevention. Arrangements should be made for comprehensive accredited and/or approved training for staff.	Recommendation accepted in principle The Government believes physical intervention must never be used as a punishment. In October 2007 the Ministry of Justice and the Department for Children, Schools and Families announced an independent review of restraint in juvenile secure settings (including secure training centres, youth offender institutions and secure children's homes). The review is chaired jointly by Andrew Williamson and Peter Smallridge.

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	This review is examining the operational efficacy, safety and ethical validity of restraint methods in secure settings, and the circumstances in which they may be used. It is also considering the system of training provided to staff using restraint in juvenile secure settings, including how such training is monitored, reviewed and accredited. Recognising the need for a joined-up approach across the secure estate for young people, the YJB issued a 'Code of Practice – Managing the Behaviour of Children and Young People in the Secure Estate' in 2006. It outlines common principles and standards in relation to methods of control, emphasising the need to place the use of physical control within an overall behaviour management strategy, and in a wider context of prevention. The National Institute of Mental Health in England / Care Services Improvement Partnership (NIMHE / CSIP) will shortly issue definitive guidance on the prevention and management of aggression and violence, and this will have a section on children and young people. The Department of Health (DH) has also responded to the Independent Review of Restraints in the Juvenile Secure Estate. DH recognises the responsibility of staff to protect children and young people from harming themselves and others. On occasions where a situation has escalated to require physical intervention, this should be done using a system that is evidence-based and causes minimal detriment to the child. DH has reviewed the use of the management of aggression and violence in health and social care settings and, following consultation with colleagues and field professionals, a new system has been developed and will be rolled out from April 2008. 'The National Minimum Standard for the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings' will be operated by Security Management Services. Security Management Services will be responsible for accrediting and registering approved courses, and for ensuring that approved trainers and sites are monitored effectively.

Continued...	The National Minimum Standards for the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings will regulate the content and standard of training. The new standards include a section for children and young people, which would be suitable for use within the under 18 secure estate where measures are taken to ensure its proper use by staff, and adherence to fixed guidelines is undertaken.

The Home Office, the Association of Chief Police Officers and the Association of Police Authorities should:

Recommendation	Action
5. Consider introducing national performance indicators for the police for child protection and the investigation of child abuse to give it due priority.	Recommendation accepted in principle A set of key performance indicators on child abuse cases has been agreed by the ACPO, HM Inspectorate of Constabulary and the Home Office following exploratory work in partnership with the Association of Police Authorities, Centrex (now National Policing Improvement Agency) and the then Department for Education and Skills (now the Department for Children, Schools and Families). Following an evaluation of the pilot by a number of Police Services, it has been agreed that the performance monitoring indicators designed to apply to police child abuse investigation units will be incorporated into the Assessments of Policing and Community Safety (APACS) framework by 2010. This will help improve performance, give prominence to child abuse investigation, and help to ensure it receives adequate resourcing.

The Department of Health, in consultation with the Royal College of Paediatrics and Child Health and the Royal College of Nursing, should:

Recommendation	Action
6. Ensure that clear guidance is drawn up for NHS organisations on role definitions and specifications for named and designated health professionals who have specific responsibilities for child protection, including arrangements to provide protected time to undertake this additional work.	Recommendation accepted in principle The competencies and role descriptions for named and designated health professionals are set out in *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (produced by the Royal Colleges and professional organisations, April 2006). The National Service Framework for Children, Young People and Maternity Services also includes, in standard 5, a description of PCTs demonstrating they are meeting their responsibilities by 'ensuring that funding is available to enable the named and designated professionals to fulfil their roles and responsibilities effectively'.

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	This is supported by the revised inter-agency guidance *Working Together to Safeguard Children*, which specifies that designated and named professional roles should always be explicitly defined in job descriptions, and sufficient time and funding should be allowed to fulfil child safeguarding responsibilities effectively.

The Youth Justice Board should:

Recommendation	Action
7. Support youth offending teams in discharging their responsibilities by advising them on their strategic role on LSCBs and providing further direction on work to safeguard children and young people.	Recommendation accepted as good practice YOTs have a statutory duty to safeguard children under the Children Act 2004. Guidance on discharging this duty is included in *Making Arrangements to Safeguard and Promote the Welfare of Children* (August 2005, revised March 2007). The revised *Working Together to Safeguard Children* (2006) also covers the role of YOTs and emphasises the need for close links between YOTs and local authority children's social care at both a strategic and operational level. The YJB has advised YOTs on all aspects of provisions related to the revised *Working Together to Safeguard Children* (2006) including YOTs' role in relation to LSCBs. YJB has also contributed to the rewriting of revised guidance on Section 11 of the Children Act 2004 (issued by the Department for Children, Schools and Families in October 2007) and is also actively involved in working with the Department for Children, Schools and Families in relation to the project to review statutory partners' assessment of the extent to which Section 11 duties are being discharged as intended. YJB has also recently drawn all YOTs' attention to Department for Children, Schools and Families training materials on safeguarding children and the new Child Death Review procedures which had to be in place in all areas by 1 April 2008. The refresh of guidance, including revised National Standards for Youth Justice, has recently been consulted on and is now expected to be made available alongside the introduction of the Youth Rehabilitation Order during 2009. This will include reference to YOTs' role on LSCBs as well as their contribution to safeguarding in general.

The Youth Justice Board and the National Offender Management Service should:

Recommendation	Action
8. Promote the personal officer role as an integral part of the team in young offender institutions; and promote good practice in safeguarding children in prison custody, especially in relation to behaviour management and the care of particularly vulnerable children.	Recommendation accepted Prison Service Order 4950 'Care and Management of Young People' (first issued 1999) requires all young people to have assigned to them 'a Personal Officer or Caseworker during their induction programme'. This was revised in 2006 to bring national safeguarding policies fully into line with the *Every Child Matters* agenda and to provide young people's establishments with templates for local policies. HM Prison Service (HMPS) has also worked to ensure that the personal officer scheme is delivered consistently across the juvenile estate. HMPS wrote to all Governors in the Young People's Estate (in November 2006), recommending that they review their local Personal Officer scheme so as to strengthen the relationship between the establishment and each young person's family and to ensure that the local scheme is arranged in such a way that changes of Personal Officer are kept to a minimum in the interests of continuity of care. This second point was also added to PSO 4950 when it was revised again in 2008. In addition, the YJB wi5ll be working with the Prison Service throughout 2008/09 to review roles and responsibilities within YOIs. The purpose of this project is to map roles and responsibilities of staff within YOIs to identify gaps and overlaps (including those relating to the personal officer scheme). This will help inform the YJB's and Prison Service's understanding of workforce requirements within YOIs to help inform future commissioning and developments including in the area of safeguarding. As a direct response to the Joint Chief Inspectors' Report 2002, the Prison Service undertook a review of safeguarding practices across the under-18 estate. As a result of this, a joint Child Protection and Safeguards three-year Programme was launched (2005-2008) with an investment of £10.5 million. The programme consists of six projects including the introduction of dedicated safeguard manager posts, local authority social workers, CCTV cameras, training models in child protection and safeguarding policy developments. This programme continued to 31 March 2008.

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	As part of this investment, a review of safeguarding was undertaken in 2007 to inform strategic direction and consider continued financial investment from 1 April 2008. The National Children's Bureau (with support from the Youth Justice Board (YJB) and Prison Service) has visited all establishments with an under-18 population for up to two days per establishment to assess their safeguarding arrangements. In addition to the work arising from the safeguarding review HMPS have provided separate accommodation for young women under 18 at new dedicated units and a Behaviour Management Programme is currently being developed with the overall aim of providing the young people's estate with more detailed guidance on effective behavioural management techniques for young people in custody, including the use of restorative justice principles, particularly in relation to rewards and sanctions, complaints and de-escalation.

HM Courts Service and Cafcass should:

Recommendation	Action
9. Promote increased participation of children in family court proceedings.	Recommendation accepted The Government is fully committed to ensuring that children and young people should have the opportunity to make their views known in decision-making concerning their future but without placing undue stress and unnecessary burdens on them if the complexity of the case does not warrant it. The Ministry of Justice (the then DCA) in September 2006 issued a consultation paper on the Separate Representation of Children. The summary of the response to this consultation paper was published in July 2007. The proposals were intended to achieve the best possible outcomes for children requiring separate representation who are experiencing parental conflict and become the subject of private law court proceedings (section 8 Children Act 1989 cases – normally about contact and residence issues). We aim to achieve this by providing children with reliable information during the course of proceedings and, subject to agreement with the judiciary, making available the opportunity of speaking to the judge or magistrates. We will also take forward proposals to establish Rules for England and Wales to improve the outcomes of the children and to reduce court delays in the interests of access to child focused justice.

Continued...	The Children and Family Court Advisory and Support Service (Cafcass), a Department for Children, Schools and Families sponsored non departmental public body, has a statutory responsibility to safeguard and promote the welfare of children in family proceedings, provide information and support for children and their families and to make provision for children to be represented in such proceedings. In 2006–07 Cafcass promoted the interests of 80,536 children and it is estimated that the total number of children it works with each year is around 100,000, which includes the work that Cafcass does with children and their families in dispute resolution and support it provides for contact centres. Section 1(3)(a) of the Children Act 1989 provides that courts shall have regard in particular to the ascertainable wishes and feelings of the child concerned. As officers of the court, Cafcass officers play a part in ensuring that children's wishes and feelings are made known to the court. Cafcass officers are expected to report on the wishes and feelings of children in their reports to court, and their responsibility is to make recommendations in the child's best interests. Cafcass is fully committed to delivering the highest quality services and is currently developing new structures and systems to drive through improvements in practice. This included, in 2007: ■ the establishment of a new Head of Safeguarding post dedicated to making sure children are protected from harm and continue to be at the centre of what Cafcass does; ■ establishment of a new feedback system so that Cafcass more rapidly learns the lessons from what children and families tell it; ■ running over 500 practitioner training courses to enable better analysis, case planning and management; ■ a new leadership development programme including the better use of supervision to support practice improvement; ■ the upgrade of Cafcass IT systems including its Case Management System to support better record keeping and performance management; ■ the creation of three national areas with Operational Directors, supported by 27 Heads of Service, to drive improvements in management and practice in their area; and

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	■ improved performance indicators, as reported to Parliament, including speedier allocations and increased time spent on dispute resolution work with families. Cafcass has also recently established a Young People's Board whose members have experience of their services and advise them on matters of policy and practice.

The Immigration and Nationality Directorate of the Home Office, in agreement with the Department for Education and Skills, should:

Recommendation	Action
10. Issue guidance to Immigration Removal Centres and local councils to ensure that: ■ a care plan, incorporating good quality health, educational and social care provision, is drawn up at the point of detention for each detained child, following an assessment in line with the *Framework for Assessment of Children in Need and their Families (2000)*; ■ continuity of education is taken into account when children are detained; ■ an investigation is carried out and a multi-disciplinary conference is convened by the local ACPC (or its successor Local Safeguarding Children Board) if the assessment shows the child to be at risk of significant harm under section 47 of the Children Act 1989, in line with *Working Together to Safeguard Children (1999)*; and ■ a multi-disciplinary review is in any event convened for any child to be detained for more than three weeks; and all assessments inform decisions on the necessity for continued detention.	Recommendation rejected Although this recommendation was rejected considerable effort has been made to improve the assessment of individual children and families and to provide any necessary family support. On 24 June 2008 the Home Office and the Department for Children, Schools and Families announced the intention for the UK Border Agency to have a legal duty to safeguard and promote the welfare of children. Other very significant activity in this area includes: ■ placing the responsibilities of the UK Border Agency (UKBA, previously BIA) towards children on a statutory basis through provision in the UK Borders Act 2007 – which will result in a Code of Practice on Keeping Children Safe from Harm. The development of this Code will be informed by a public consultation and will be subject to Parliamentary approval; ■ establishing the post of Children's Champion at Director level reporting to UKBA's Chief Executive to act as the organisation's 'critical friend' and catalyst of improvements; ■ regular meetings between UKBA and the Office of the Children's Commissioner for England to consider issues including matters relating to the detention of children; ■ work with the Association of Directors of Children's Services to enhance joint working with and referral to local authorities; and ■ the establishment of a protocol to support better partnership working with Cafcass.

Continued...	In particular, arrangements for assessing the welfare of children detained with their families for longer than 72 hours (these families are accommodated at Yarl's Wood Immigration Removal Centre) have been strengthened significantly in recent years by: ■ establishing a formal working relationship with the Bedfordshire LSCB; ■ the full-time secondment to the family unit of two experienced social workers from the local authority; ■ weekly assessments of the welfare of every child – to which healthcare, nursery, education and family unit staff as well as the social workers contribute; ■ written assessments – based on the Common Assessment Framework – of the welfare of each child who is to be detained for longer than 28 days (these assessments commence once the child has been detained for three weeks); ■ a facility for the social worker or other Yarl's Wood staff to initiate emergency ad hoc conference calls on individual families in urgent need with UKBA decision makers; ■ a weekly case-conference at which the continued detention of a child for longer than 28 days is scrutinised; ■ the authorisation of the continued detention of each child beyond 28 days by the Immigration Minister; ■ the opportunity for children of primary and secondary school age to continue their educational studies and the opportunity for younger children to engage in nursery activities; ■ the provision of youth worker and counselling services to help meet the particular needs of children in detention; ■ the development of an agreed procedure with Bedfordshire LSCB to refer children who are thought to be at risk of significant harm for investigation by the local authority and police child abuse investigation team; and ■ an information sharing protocol (in development) to ensure local authorities are routinely consulted before children in need are detained.

A Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

All agencies and organisations directly involved with children should:

Recommendation	Action
11. Review their approach to safeguarding, in line with the requirements of the Children Act 2004 and guidance, in order to: ■ identify the relevant safeguarding issues specific to their area of work; ■ ensure that there are policies and procedures in place to address these issues; and ■ put in place regular quality assurance and monitoring systems to ensure that policy is followed through consistently in practice, and demonstrates effective outcomes.	Recommendation accepted as good practice The then Department for Education and Skills (DfES) published updated guidance, *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the children act 2004*, in March 2007. This guidance makes clear that 'Agencies' responsibilities for safeguarding and promoting the welfare of children, including the arrangements they make under section 11, will be monitored through LSCBs.' To help LSCBs develop their role and learn from one another, the Government has hosted two national events for LSCBs, in March 2007 and March 2008. The *Staying safe: action plan* (February 2008) also includes the commitment to issue a collection of readily accessible resources to clarify issues on LSCBs' roles and responsibilities and facilitate improvement of LSCBs' performance and effectiveness, to include non-statutory practice guidance, a good governance toolkit and exemplars of effective practice. The Department for Children, Schools and Families has commissioned research into how the agencies subject to section 11 of the Children Act 2004 are complying with its requirements.
12. Ensure that staff working with or in contact with: ■ children with disabilities; ■ children in private fostering situations; and ■ asylum-seeking children know how to recognise the signs of abuse or neglect and which procedures to follow in such cases.	Recommendation accepted as good practice The revised *Working Together to Safeguard Children* sets out the responsibility of LSCBs to ensure that multi-agency training on safeguarding and promoting welfare that meets local needs is provided. The Government recognises that disabled children are particularly vulnerable to abuse. To support those working with disabled children, the Department for Children, Schools and Families published guidance for LSCBs on safeguarding disabled children in February 2006 and plans to launch new practice guidance on safeguarding disabled children in line with *Working Together to Safeguard Children*, as set out in the *Staying safe: action plan* (February 2008).

Continued...	Local authorities have a duty to satisfy themselves as to the welfare of children in private fostering situations. An officer of the local authority must make an initial visit to the child immediately and subsequent visits every six weeks during the first year and every 12 weeks in following years for the duration of the arrangement. Local authorities have a responsibility to promote awareness of the need for parents, private foster carers and others (including professionals such as teachers and GPs) to notify their local authority of new and existing private fostering arrangements. Statistics have been published each year since 2005 on numbers of children being privately fostered. This has seen a steady increase in notifications from 640 in 2004–05 to 1,570 in 2006–07. The Commission for Social Care Inspection started a three-year programme of inspections of local authority measures to promote awareness and the effectiveness of local authority visiting and monitoring arrangements for private fostering. This has now been taken over by Ofsted. As part of preparations to implement the provision in the UK Borders Act 2007 which places the UKBA's duties towards children on a statutory footing, UKBA has published for consultation a Code of Practice on keeping children safe from harm.
13. Audit their recruitment and staff checking procedures so that the following practices are carried out consistently: ■ references are always verified and properly recorded in staff files; ■ a full employment history is available on file for every member of staff, any gaps in employment history are checked and accounted for and qualifications are checked; and ■ enhanced Criminal Records Bureau (CRB) checks are consistently undertaken on new staff and those working with children who have not previously been subject to checks, including temporary, agency or contract staff, prior to the establishment of the centralised vetting and barring scheme proposed in response to the Bichard recommendations.	Recommendation accepted as good practice Following the review of List 99 in 2006, the Government put in place stronger regulations and guidance relating to safe recruitment in the education sector. These new requirements are set out in *Safeguarding Children and Safer Recruitment in Education* and include: ■ a requirement for a CRB Enhanced Disclosure for all new appointments to the schools workforce; ■ a requirement for a CRB Enhanced Disclosure for new appointments to FE colleges which are providing education and are regularly caring for, training, supervising or being solely in charge of persons aged under 18; ■ a requirement for schools and FE colleges to keep a single central record detailing a range of checks carried out on their staff (for FE colleges this relates to staff providing education);

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	■ appointments of those who have lived outside the United Kingdom are subject to such additional checks as are deemed appropriate where the required CRB Enhanced Disclosure is not considered sufficient to establish suitability to work with children and young people; ■ schools and FE colleges (for staff providing education) must satisfy themselves that supply staff have undergone the necessary checks to assess their suitability for the post; and ■ identity checks must be carried out before the appointment is made. In response to Recommendation 16 of the Bichard inquiry, the Government commissioned the National College of School Leadership (NCSL) to develop an online training package on safer recruitment practices, and will continue to work with NCSL and other key stakeholders to maximise the numbers of heads and nominated governors successfully completing this training. NCSL is continuing to run events to train trainers in the delivery of the Safer Recruitment workshop materials to school staff at local level. The Government will also roll out safer recruitment training for the post-16 education and training sector run by the Centre for Excellence in Leadership and the NCSL. We will also work with the Children's Workforce Development Council (CWDC) on new guidance on safer recruitment for the whole of the children's workforce. The new Independent Safeguarding Authority (ISA) scheme, which will be rolled out from October 2009, will require all those wishing to work with children and young people, whether in a paid or unpaid capacity, to be subject to rigorous vetting and barring checks. The ISA scheme will also be constantly updated to ensure that employers and those who manage volunteers are provided with up to date information about a person's ISA status.
14. Review existing safeguarding policies to ensure that they take full account of the needs of children with disabilities and assess the professional development needs of staff who work with children with disabilities to equip them to: ■ communicate effectively with children; ■ identify potential child protection concerns; ■ track and monitor behaviour patterns; and ■ follow appropriate child protection procedures.	Recommendation accepted as good practice The Government recognises the need to target policies to protect disabled children and promote their welfare. The Government commissioned the Council for Disabled Children to produce resources for LSCBs to help them protect and promote the welfare of disabled children (*Safeguarding Disabled Children – a resource for Local Safeguarding Children Boards*, February 2006).

Continued...	*Aiming high for disabled children: better support for families* (May 2007) sets out the Government's plans for improving service provision for disabled children and their families. The *Staying safe: action plan* (February 2008) proposes a range of new commitments to provide better protection for disabled children, including: ■ publishing new practice guidance on safeguarding arrangements; ■ publishing guidance in spring 2008 to help schools tackle the bullying of children with learning difficulties and/or disabilities; ■ working with the Healthcare Commission on measures to hold PCTs to account in providing services for children and young people, including those with disabilities.

Local councils and partner agencies should:

Recommendation	Action
15. Ensure, when developing Children and Young People's Plans, that: ■ they reflect priorities for safeguarding as well as for universal and preventive services; and ■ thresholds for specialist services are consistent with ensuring that children are safeguarded effectively.	Recommendation accepted as good practice All areas have a children and young people's plan (including those that do not need to according to children and young people's plan regulations). In 2007, the Government strengthened the requirements for children and young people's plans including adding a reference in regulations to the section 11 duty. This has made more explicit the need to consider safeguarding when developing and delivering the plans. Ofsted evaluation of children and young people's plans showed that local authorities are developing plans which genuinely reflect local needs as well as reflecting key national priorities including safeguarding children.

Local councils should:

Recommendation	Action
16. Ensure, in introducing the Common Assessment Framework, that sufficient priority and adequate resources are given to delivering their responsibilities to safeguarding children effectively.	Recommendation accepted as good practice The Government issued guidance for local authorities to coincide with the national roll out of the CAF from April 2006.

A Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	This guidance consisted of a number of documents, including implementation guidance, aimed at directors of children's services. The implementation guidance covered a range of factors for consideration, including the planning of resources and multi-agency working, and is designed to help organisations deliver their responsibilities, including safeguarding responsibilities. The CWDC reviewed this guidance in 2007, and is now responsible for it. The guidance will be reviewed again during 2008 in the light of an evaluation of integrated working implementation that CWDC is currently carrying out.
17. Ensure that safeguarding requirements are consistently applied to looked after children in all settings, including: ■ children placed for adoption; ■ children on care orders placed with parents; and ■ children placed with extended family.	Recommendation accepted as good practice The National Minimum Standards for Children's social care all include specific standards relating to safeguarding requirements. The Children and Young Persons Bill, which at the time of writing is before Parliament, provides for local authorities to maintain effective contact with children in care by making explicit the duty for social workers to visit all looked after children including those placed in children's homes, in supported independent living and those in youth custody. The Adoption and Children Act 2002 strengthened existing practices to safeguard children placed for adoption. Under the 2002 Act, the child's welfare is the paramount consideration in all decisions relating to adoption. From 30 December 2005 a court or adoption agency must have regard to the welfare checklist (section 1(4) of the 2002 Act) when coming to any decision relating to the adoption of a child. Included in this welfare checklist is 'any harm (within the meaning of the Children Act 1989) which the child has suffered or is at risk of suffering'. As part of the work programme to implement the 2002 Act, the Department for Education and Skills rolled out training materials through 75 two-day, multi-agency workshops locally throughout England in October and November 2005. The workshops were designed to highlight awareness of the changes in the legislation, for example the improved review and visit regime, which will equip trainers and champions within local authorities, voluntary adoption agencies and Cafcass to cascade tailored training within their organisations drawing on the flexible learning materials developed by the Department for Education and Skills.

Continued...	Where a looked after child is placed with a member of their extended family or a friend of the family the carer must be assessed and approved as a foster carer in the same way as any other foster carer, and the placements should be monitored and supported in the same way as any other foster placement.
18. Ensure that robust arrangements for safeguarding looked after children are in place, including: ■ specific safeguarding requirements in all placement contracts; and ■ effective monitoring arrangements, including regular visits by social workers.	Recommendation accepted as good practice The Department for Children, Schools and Families is making the requirement to visit children in care explicit for all placements. The Care Matters implementation plan (*Care Matters: Time to Deliver for Children in Care*) published jointly by the Department for Children, Schools and Families, the Association of Directors of Children's Services and the Local Government Association, includes the requirement that social workers visiting children in placements will normally see the child alone and away from their carers. The Department for Children, Schools and Families is also introducing an explicit requirement for local authorities to ensure that young people have appropriate opportunities to contact their social worker and seek advice outside of visits, as well as extending the requirement to visit children in care to those children who were voluntarily accommodated immediately before entering custody. The Department for Children, Schools and Families recognises that the frequency of visits will depend on the individual child's needs and that some children will require more frequent visits than others. Children's social workers are best placed to make this assessment.
19. Ensure that unaccompanied asylum-seeking children receive a comprehensive assessment of their needs and that appropriate services are put in place.	Recommendation accepted as good practice All unaccompanied asylum-seeking children should be provided with the same quality of individual assessment and related services as any other child presenting as being 'in need'. Once unaccompanied asylum-seeking children are accommodated children under Section 20 of the Children Act 1989 then they will be required to be the subject of a care plan (pathway plan at 16+) which must be based on a comprehensive assessment of their needs, taking account of the following dimensions: ■ health (including mental health such as whether post-traumatic support and counselling is needed); ■ education; ■ emotional and behavioural development;

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	■ identity; ■ family and social relationships; ■ social presentation; and ■ self-care skills, including the child's understanding of the implications of their immigration status and the skills required to manage transitions. The responsible local authority should provide services for the unaccompanied asylum-seeking children on the basis of the above assessment, irrespective of their immigration status. To provide better outcomes for unaccompanied asylum-seeking children, the Government will implement reforms as set out in *Better Outcomes: The Way Forward. Improving the care of unaccompanied asylum-seeking children* (2008). The UKBA has also recently announced its plans for improving support to unaccompanied asylum-seeking children, and trafficked children who claim asylum, by locating them with specialist local authorities who will assess and meet their needs for support and protection, whilst the UKBA resolves their immigration status more quickly, helping to remove the uncertainty faced by many young people in this situation. Revision of the Children Act Guidance which will be necessary to implement clauses in the Children and Young Persons Bill (currently before Parliament) and the wider Care Matters reform programme (*Care Matters: Time to Deliver for Children in Care*, 2008) will provide the Government with the opportunity to consider whether it will be necessary to revisit existing guidance LAC (2003)13 to provide more information about best practice in assessing the needs of unaccompanied asylum-seeking children so that they are provided with appropriate services that keep them safe and meet the full range of their needs.
20. Ensure, when children are placed in residential special schools, that their needs are assessed under the *Framework for the Assessment of Children in Need and their Families* to inform the care plan.	Recommendation accepted as good practice All children placed in a residential special school, other than in exceptional circumstances, will have a statement of special educational needs (SEN) which names that school. This statement will include advice from social care as well as from other services. Where the social care assessment for the statement identifies issues which suggest the child may be 'in need' under the Children Act 1989, the child should also be assessed under the Framework for the Assessment of Children in Need and their Families, 2000.

Continued...	Local authorities and schools are required by statute to have regard to the *SEN Code of Practice*. Paragraph 10:35 says that 'At the same time as the LEA is carrying out a statutory assessment under section 323 of the Education Act 1996, a Social Services Department may decide to undertake a child in need assessment under section 17 of the Children Act 1989 to ascertain whether social services help may benefit the child or their family. This assessment will be undertaken in accordance with the DH, et al., Framework for the Assessment of Children in Need and their Families (2000) to which teachers and other educational professionals will be expected to contribute.'
21. Put plans in place to ensure that good working relations between professionals, especially teachers and social workers, are actively promoted.	Recommendation accepted as good practice The Children Act 2004 included the requirement for all local authorities to appoint, or have a vacant post to which they are in the process of appointing, a Director of Children's Services by 1 January 2008. All authorities now have Children Act-compliant directors of children's services in place. These key posts bring together local authority responsibilities for social care and education. Guidance produced under the Children Act 2004 makes clear the importance of the role of the directors of children's services and children's trusts arrangements in bringing about the cultural change necessary for effective multi-agency working: ■ Guidance on the Duty to Cooperate to Improve Well-being of Children (Children's Trusts) (2005). ■ Guidance on the Roles and Responsibilities of the Director of Children's Services and the Lead Member for Children's services (2005). ■ Guidance on the Duty to Safeguard and Promote the Welfare of Children (2005) stresses the importance of all professionals working with children, including teachers and social workers, working effectively together to safeguard vulnerable children and improve outcomes for all children. In addition, the Government has published a CAF, based on and compatible with the Assessment Framework, for use by practitioners in schools and other settings, to help embed a common language among practitioners. Evaluation of children's trust pilots noted that, although there were still challenges in managing complex interdisciplinary relationships, children's trusts have: 'facilitated the development of new types of professionals who are able to work across long-standing organisational and professional boundaries'.

Appendix A: Progress against recommendations made in *Safeguarding children* (2005)

Continued...	The Children's Plan (2007) further emphasises the importance of effective integrated working, with schools having timely access to more specialist provision including social care. The forthcoming Workforce Action Plan (to be published in 2008) will include plans to build the capacity, supply and skills of social workers to effectively make assessments and decisions to carry out their statutory safeguarding duties, engage in earlier intervention and in both areas work more effectively with other professionals.
22. Develop parallel pathway plans for unaccompanied asylum-seeking children who have been given discretionary leave to remain in the UK to age 18, taking account of the uncertainty about what immigration decision will be made at that time.	Recommendation accepted as good practice This remains accepted good practice – pathway planning for unaccompanied asylum-seeking children care leavers should already take into account uncertainty about immigration status and the likelihood that their asylum application will be refused so that the young person can be supported to consider options of return. On 31 January 2008 the Home Office published *Better Outcomes: the Way Forward*. This includes a commitment to produce updated guidance based on this 'twin track', or parallel, approach to care planning so that support is provided to both successful and unsuccessful asylum applicants.

Local councils and NHS trusts should:

Recommendation	Action
23. Establish clear arrangements, when a looked after child is placed out of their area, for notifying NHS Trusts in the area where they are placed, in line with the National Service Framework for Children, Young People and Maternity Services.	Recommendation accepted as good practice There is already a clear statutory duty (under the Arrangements for Placement of Children (General) Regulations 1991, as amended) on the authority responsible for looking after a child which places the child in another authority's area to inform the local authority, the local education authority and the PCT for the area in which the child is now living. The Department for Children, Schools and Families and DH are in the process of revising the health guidance, *Promoting the Health of Looked after Children,* which will be placed on a statutory footing for local authorities and healthcare bodies. This revised guidance will be published for consultation in 2008. Currently, the guidance, published by DH in 2002, states that councils with social services responsibilities should have agreements and protocols with relevant health service providers which enable arrangements for meeting a looked after child's health needs to be made prior to placement.

NHS trusts and independent hospitals should:

Recommendation	Action
24. Develop robust protocols for: ■ post-mortems, to ensure that staff are aware of the criteria for a Serious Case Review, and how to request that a case is considered for a Serious Case Review through the Area Child Protection Committee (ACPC), and subsequently the LSCB; and know which cases of death must be referred to, or discussed with, the Coroner, and, for cases not referred to the Coroner, are familiar with the process of gaining consent for post-mortem examination; and ■ ensuring that staff working with children who spend more than three months in hospital notify social services about these children to trigger an assessment, under the Framework for the Assessment of Children in Need and their Families, and follow up of their welfare needs.	Recommendation accepted as good practice Since the publication of *Safeguarding children* (2005 report), the Human Tissue Act 2004, which set out clear principles of what constitutes appropriate consent for both adults and children, has come into force. In addition, the Human Tissue Authority – which was established under the Act as the regulatory body for all matters concerning the removal, storage, use and disposal of human tissue for specified purposes – has published codes of practice on both post-mortem examinations and consent. These two codes together provide practical guidance on the obtaining of consent for post-mortem examination. The procedures which should be followed when a child dies unexpectedly are set out in chapter 7 of *Working Together to Safeguard Children* and came into force, along with the relevant part of the LSCB Regulations 2006, in April 2008. Child death overview panels are responsible for reviewing information on all child deaths, and are accountable to the LSCB Chair. The Department for Children, Schools and Families has produced material to support child death review processes, including the DVD *Why Jason Died* (DCSF, 2007), which illustrates the roles and responsibilities of those responding to unexpected deaths within the context of the LSCB's responsibilities. The requirement for referral for assessment to be made to social services whenever a child spends more than three months in hospital is covered in section 5.18 of the revised statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (published 2007).

B Appendix B: Inspectorates' role and remit

Ofsted: The Office for Standards in Education, Children's Services and Skills

The new Ofsted – the Office for Standards in Education, Children's Services and Skills – came into being on 1 April 2007. It brought together the wide experience of four formerly separate inspectorates for education and children's social care services: the Adult Learning Inspectorate (ALI), the Commission for Social Care Inspection (CSCI), the office of Her Majesty's Inspectorate of Court Administration (HMICA) and the Office of Her Majesty's Chief Inspector of Schools (Ofsted). The new Ofsted consolidates the strengths of the four predecessor inspectorates under one familiar name with the aim of 'raising standards and improving lives'. Ofsted does not report to government ministers but directly to Parliament through the *Annual Report of Her Majesty's Chief Inspector.*

Statement of purpose: Ofsted inspects and regulates to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. We want to raise aspirations and contribute to the long-term achievement of ambitious standards and better life chances. We believe that improved educational and economic opportunities and social well-being will in turn promote England's national success. The Education and Inspections Act 2006, which established the new Ofsted, specifically requires that everything Ofsted does should promote service improvement by ensuring that these are efficient, effective and promote value for money through a focus on the interests of their users.

Values: Our values underpin everything we do and how we do it.

- Putting children and learners first.
- Achieving excellence.
- Behaving with integrity.
- Valuing people's differences.

The different types of inspection: We inspect or regulate the following services:

- childcare providers
- adoption and fostering agencies
- children's homes, including those in the secure estate
- residential family centres run by local authorities
- all state maintained schools, including pupil referral units, and some independent schools
- the Children and Family Courts Advisory and Support Service (Cafcass)
- local authority services for children and young people
- further education providers
- initial teacher training providers
- all publicly funded and some privately funded adult education and training.

We also support wider service improvement through a variety of thematic inspections and surveys.

The reports: All reports set out our findings and include recommendations for improvement or highlight strengths, as appropriate. All reports are available at:

www.ofsted.gov.uk

Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales. In England, the Commission is responsible for assessing and reporting on the performance of both NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. The Commission also encourages providers to continually improve their services and the way they work.

Statement of purpose: The Healthcare Commission promotes improvements in healthcare and public health through assessment and inspection. The Commission equips patients and the public with the best possible information about the provision of healthcare. Our vision, therefore, is to make a difference to the delivery and quality of healthcare by inspecting, informing and improving.

The Health and Social Care Act 2003 states that the Healthcare Commission must pay particular attention to 'the need to safeguard and promote the rights and welfare of children'. The Commission does this through the implementation of a programme of assessment and inspection work, both specifically for children's services and where children's healthcare forms part of the wider remit.

Values: The Healthcare Commission aims to:

- promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- be independent, fair and open in our decision making, and consultative about our processes
- safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.

These aims are reflected in all aspects of the work of the Commission.

The different types of inspection: The Commission inspects the quality and value for money of healthcare and public health by:

- assessing the performance of the NHS using standards set out by the Department of Health and the best available evidence; a specific standard (C2) covers arrangements in place to safeguard children
- registering and inspecting individuals and organisations that provide independent healthcare services
- providing a second-stage complaints resolution service where patients or carers are not content with the local resolution by the organisation
- conducting service reviews and investigations into specific areas of NHS provision and publishing national and local findings.

The reports: The Commission equips patients and the public with the best possible information about the provision of healthcare by: producing an annual rating for each NHS trust in England; publishing an annual report on the state of healthcare in England and Wales, which is presented to Parliament; providing the best possible information on the performance of healthcare organisations so that they can make informed decisions about their healthcare.

www.healthcarecommission.org.uk

B Appendix B: Inspectorates' role and remit

Commission for Social Care Inspection

The Commission for Social Care Inspection (CSCI) is an independent body which publishes annual reports to Parliament on the state of social care in England and on how we are carrying out our functions.

Statement of purpose: CSCI is the inspectorate for adult social care in England. We assess the performance of all English councils with adult social care responsibilities and inspect and regulate all adult social care services in the public, private and voluntary sectors. CSCI continues to be responsible for some children and children's services, and retains its statutory duty to safeguard and promote the rights and welfare of children in regulated services. We work closely with Ofsted in relation to areas of interface (e.g. the transition of young people with disabilities and complex needs into adulthood; the impact of adults' problems on children; and issues in relation to young carers). The introduction of quality ratings for all adult care providers in 2008 will provide an easy-to-understand rating system, enabling people to make comparisons and choose which service is right for them.

Values: We put the people who use services at the centre of all we do. From the beginning we have committed to four core values and these continue to be central to our vision.

- Putting the people who use social care first.
- Improving services and stamping out bad practice.
- Being an expert voice on social care.
- Practising what we preach in our own organisation.

The different types of inspection

- CSCI assesses whether local councils use their resources effectively when providing social care services for adults, and whether value for money is being achieved nationally.
- CSCI registers all social care services for adults and checks whether they meet legal requirements.
- CSCI inspects adult social care services against national minimum standards set by the Government.
- CSCI takes enforcement action when services do not meet minimum standards.

The reports: Inspections of regulated services are set against the Government's national minimum standards.

Our inspection reports highlight how well services provide good outcomes for those people who use them and set out what needs to be done to make improvements. We publish a quality rating for each care home and care service, which sets out how well a registered service is doing against national standards. We publish reports of our inspections of council adult social care services. These reports set out our key findings and suggest ways that councils may improve. An inspection report might provide details of an inspection that looked at a council's performance across one to three different themes. We publish annual reports on the performance of councils in providing social care services to adults. These reports are set out against the Performance Assessment Framework and each council is given a star rating on how well it delivers services.

www.csci.org.uk

HM Inspectorate of Constabulary

HMIC is independent of both the Government and the Police Service. Its core role is to promote efficiency and effectiveness of police forces and policing organisations in England, Wales and Northern Ireland through inspection and assessment. It also provides impartial professional advice to Ministers, chief constables and police authorities.

While the inspectorate was established under legislation in 1856, numerous further enactments have extended its remit to provide similar scrutiny to other policing bodies, such as the British Transport Police, the Serious and Organised Crime Agency (SOCA) and elements of Her Majesty's Revenue and Customs (HMRC).

In 2008, HMIC remains the principal advisor to the Home Secretary on professional policing matters.

Statement of purpose: To promote efficiency and effectiveness through assessment and inspection of organisations and functions for which we have responsibility, to ensure: that performance is improved; good practice is spread; and standards are agreed, achieved and maintained. Also to provide advice and support to criminal justice partners and play an important role in the development of future police leaders.

Values: HMIC's inspection approach is fully in line with the Government's principles of inspection. In particular, HMIC applies an impartial, proportionate and evidence-based approach to identifying areas of concern.

The different types of inspection: HMIC does not currently engage in any rolling programmes of inspection of police forces; all inspection is informed by risk assessment, whether to decide which forces to inspect on a given theme or to identify generic issues for assessment in all forces.

Since 2008, HMIC has focused core inspection activity on the 'protective' policing services – for example dealing with serious and organised criminality; critical incident management; and counter-terrorism – and strategic services – such as performance management and diversity. There has also been a full programme of inspection of neighbourhood policing and citizen focus.

We are also asked to lead targeted reviews, commissioned by the Government following high profile cases or perceived failures in policing – for example re-examining the investigation of the Soham murder in 2003.

The reports: All HMIC inspection reports are submitted to the Secretary of State, copied to the inspected organisations and published – unless there are specific issues of potential compromise to operational integrity, national security or other statutory or legal impediment. In force-specific reports, both good and poor practice is highlighted. In national thematic reports, HMIC seeks to 'name and praise' but not to 'name and shame'. This encourages full disclosure of poor practice for the wider benefit of the service as a whole.

www.inspectorates.homeoffice.gov.uk/hmic

B Appendix B: Inspectorates' role and remit

HM Crown Prosecution Service Inspectorate

HM Crown Prosecution Service Inspectorate (HMCPSI) is an independent statutory body that inspects the Crown Prosecution Service (CPS) and the Prosecutions Office of HM Revenue, Customs and Excise and reports to the Attorney General on the operation of these departments. In relation to the CPS, it inspects and evaluates the quality of casework decisions, casework processes and all aspects of management that support the prosecution process. It advises the Director of Public Prosecutions (DPP) on the performance of each CPS Area, HQ Directorates and of the CPS as a whole in relation to these issues.

Statement of purpose: To enhance the quality of justice through independent inspection and assessment of prosecution services, and in so doing improve their effectiveness and efficiency. HMCPSI achieves this by: bringing about improvement through acting as a major driver for increasing performance in the prosecution authorities that it is responsible for inspecting; encouraging joined-up working within the criminal justice system (CJS); providing assurances to the Attorney General as to the performance of the CPS and other prosecution authorities; and contributing to greater value for money within the prosecution service and the CJS as a whole. HMCPSI works extensively with other criminal justice inspectorates to deliver a joint programme of cross-cutting work.

Values: We endeavour to be true to our values, as defined below, in all that we do:

- consistency
- thoroughness
- integrity
- professionalism
- objectivity.

Taken together, these mean that we demonstrate integrity, objectivity and professionalism at all times and in all aspects of our work and that our findings are based on information that has been thoroughly researched, verified and evaluated according to consistent standards and criteria.

The different types of inspection: We carry out several types of inspection:

- inspections of CPS Areas and business units – considering the quality of casework decisions and casework decision-making processes in the CPS and all aspects of management performance
- thematic reviews of CPS activity – taking an in-depth look at a particular issue that may be causing current national or local concern
- inspections of other prosecution authorities, for example the Revenue and Customs Prosecutions Office
- thematic reviews carried out jointly with other criminal justice inspectorates
- inspections of criminal justice areas carried out jointly with other criminal justice inspectorates.

The reports: Our reports are published and sent to the Attorney General, the DPP and others, including those who have assisted in our inspection.

www.hmcpsi.gov.uk

HM Inspectorate of Court Administration

Her Majesty's Inspectorate of Court Administration (HMICA) is an independent inspectorate. The Chief Inspector reports directly to the Lord Chancellor.

HMICA's remit is to inspect the administration of the Crown, county and magistrates' courts but not to 'inspect persons making judicial decisions or exercising judicial discretion'. We work closely with the judiciary to ensure that our work respects their independence while contributing to improvements in performance and service provision to court users.

Statement of purpose: To inspect and report to the Lord Chancellor on the system that supports the carrying on of the business of the courts (the Crown Court, county courts and magistrates' courts) and the services provided for those courts.

Values: In line with government policy, HMICA inspection activity:

- is independent of the service providers
- provides assurance to Ministers and the public about the safe and proper delivery of these services
- contributes to the improvement of these services
- is reported in public
- delivers value for money.

The different types of inspection

In order to inspect court administration not subject to review by other bodies, HMICA has identified the following key areas for inspection:

- promoting diversity
- public governance and accountability
- leadership and strategic management
- finance
- people
- building, IT and equipment
- court administration process
- enforcement
- quality of service.

HMICA also undertakes joint inspections with other inspectorates and organisations, such as Victim Support, and thematic reviews focusing on particular issues in order to establish current performance and identify examples of good practice. In addition, the inspectorate also offers advice to the Ministry of Justice, HMCS and professional bodies and other organisations on matters which arise from inspections and thematic reviews.

The reports

HMICA publishes timely reports which include findings and recommendations. All publications are available at:

www.hmica.gov.uk

Appendix B: Inspectorates' role and remit

HM Inspectorate of Prisons

The Chief Inspector reports directly to the Justice Secretary on conditions in prisons and the treatment of prisoners in England and Wales and other matters as directed by the Justice Secretary. The inspectorate also reports to the Home Secretary on conditions and treatment in all places of immigration detention in the United Kingdom. In addition, the Chief Inspector is invited routinely to inspect the Military Corrective and Training Centre, Colchester and prisons in Northern Ireland, the Channel Islands and the Isle of Man.

Statement of purpose: To provide independent scrutiny of the conditions for and treatment of prisoners and other detainees, promoting the concept of 'healthy prisons' in which staff work effectively to support prisoners and detainees to reduce re-offending or achieve other agreed outcomes.

Values: HMI Prisons independently inspects the treatment and conditions of those held in custody according to criteria informed by international human rights instruments and best practice – as well as the rules, orders and standards of the agencies inspected. Its methodology is concerned with assuring the public about custodial effectiveness, including practical issues of humanity and decency so essential to healthy custodial outcomes. The inspectorate is committed to promoting equal opportunity and adheres to the Government's principles for inspection: impartiality, proportionality, transparency and user focus.

The different types of inspection: The inspectorate's programme of inspection is based on a mixture of chronology and risk assessment. Full inspections run on a five- or three-year cycle; all unannounced follow-up inspections run on a risk-assessed basis. The types of inspection include:

- Full inspections – lasting for at least one week, information is collected from many sources, including staff and visitors, those who are imprisoned or detained, and all documentation held. Inspection findings are fed back to the Governor and key staff throughout the inspection. A formal debrief to the Governor and senior managers is held on the last day.
- Follow-up inspections – all establishments will have unannounced and proportionate follow-up inspection between full inspections. Shorter follow-up inspections are also conducted where the previous full inspection and our intelligence suggests there are comparatively fewer concerns.
- Immigration detention inspections – every immigration removal centre receives a full announced inspection every three years. Interim unannounced follow-up inspections are conducted on a risk-assessed basis.
- All non-residential short-term holding facilities (STHFs) – are inspected on a six-year cycle. All residential STHFs are inspected on a four-year cycle. All STHF inspections are unannounced.
- Three inspections of **detainee escorts** are conducted every year.

In addition, the inspectorate undertakes a programme of thematic inspections and takes part in the annual programme of joint criminal justice inspections.

The reports: All inspection reports are published, in a form and at a time decided by the Chief Inspector, which should be within 16 weeks of the inspection. All reports are available at:

www.inspectorates.homeoffice.gov.uk/hmiprisons

HM Inspectorate of Probation

HMI Probation is an independent inspectorate, funded by the Ministry of Justice.

Statement of purpose: To report to the Home Secretary on the effectiveness of work with individual offenders, children and young people aimed at reducing offending and protecting the public, whoever undertakes the work under the auspices of the National Offender Management Service or Youth Justice Board. To:

- report on the effectiveness of the arrangements for this work, working with other inspectorates as necessary
- contribute to improved performance by the organisations we inspect
- contribute to sound policy and effective service delivery, especially in public protection, by providing advice and disseminating good practice, based on inspection findings, to Ministers, officials, managers and practitioners
- promote actively race equality and wider diversity issues in the organisations we inspect
- contribute to the overall effectiveness of the Criminal Justice System, particularly through joint work with other inspectorates.

Values: While carrying out our work, we aim in particular to follow the Government's 10 principles of inspection in the public sector. To achieve our purposes and meet these principles, we aim to:

- work in an honest, professional, fair and polite way
- report and publish inspection findings and recommendations for improvement in good time and to a good standard
- promote race equality and wider aspects of diversity in all aspects of our work
- minimise the amount of extra work arising for probation areas or youth offending teams as a result of the inspection process.

The different types of inspection: Nearly all our inspections are conducted jointly with other inspectorates. They consist of:

- The Offender Management Inspection – which we lead and which entails visits to all 42 National Offender Management Service (NOMS) areas to assess the service delivered to offenders against our published criteria.
- The Youth Offending Team Inspection – which we also lead and involves visits to all YOTs in England and Wales; its primary purpose is to assess the quality of service to children and young people who have offended or who are at risk of offending.
- Thematic inspections – we undertake a number of thematic inspections each year with other inspectorates looking at issues of mutual concern or interest.
- Special inquiries – we also undertake special inquiries into specific cases on occasion at the request of Ministers.

The reports: Our reports, setting out our findings on probation areas and youth offending teams, are published approximately three months after our fieldwork. They include recommendations for improvement as well as highlighting examples of good practice. All reports are available at:

http://inspectorates.justice.gov.uk/hmiprobation

C Appendix C: Steering group and editorial group members

A steering group was set up to manage the third joint Chief Inspectors' Review of Children's Safeguards. Responsibility for co-ordinating the project transferred from the Commission for Social Care Inspection to Ofsted in April 2007. An editorial group was responsible for analysing the evidence, identifying the key findings and overseeing the production of the report.

Steering group

- Chair: Janet Galley, HMI, Ofsted (to 31 March 2008)
  Anne Orton, HMI, Ofsted (from 1 April 2008)
- Lead Inspector: Anna Lis, HMI, Ofsted
- Michael Hart, Ofsted
- Juliet Winstanley, HMI, Ofsted
- Chris Batty, HMI, Ofsted
- Arran Poyser (to 31 March 2008)
- Ruth Campbell, Ofsted
- Maddie Blackburn, Healthcare Commission (to 7 February 2008)
- Fergus Currie, Healthcare Commission (from 7 February 2008)
- Liz Calderbank, Her Majesty's Inspectorate of Probation
- Jerry Hyde, Her Majesty's Crown Prosecution Service Inspectorate
- Peter Todd, Her Majesty's Inspectorate of Constabulary
- Roger Morgan, Children's Rights Director
- Mike Lindsay, Adviser to Children's Rights Director
- Nigel Thompson, Commission for Social Care Inspection
- Peter Clarke, Department for Children, Schools and Families

Editorial group

- Chair: Anna Lis, HMI, Ofsted
- Vanessa Couchman, OFB International, report author
- David Howarth, Ofsted
- John Cordwell, HMI, Ofsted
- Arran Poyser, HMI, Ofsted (to 31 March 2008)
- Maddie Blackburn, Healthcare Commission (to 7 February 2008)
- Fergus Currie, Healthcare Commission (from 7 February 2008)
- Fay Deadman, Her Majesty's Inspectorate of Prisons
- Mike Lindsay, Adviser to Children's Rights Director
- Dan Parks, Her Majesty's Inspectorate of Probation
- Deborah Peters, Her Majesty's Crown Prosecution Service Inspectorate
- Jane Sisson-Pell, Her Majesty's Crown Prosecution Service Inspectorate
- Nigel Thompson, Commission for Social Care Inspection
- Lesley Warrender, Her Majesty's Inspectorate of Constabulary

Appendix D: Abbreviations

D

- Adult Learning Inspectorate (ALI)
- Annual performance assessment (APA)
- Area Child Protection Committee (ACPC)
- Area effectiveness inspections (AEIs)
- Assessments of Policing and Community Safety (APACS)
- Association of Chief Police Officers (ACPO)
- Attention deficit hyperactivity disorder (ADHD)
- Basic command units (BCUs)
- Child and adolescent mental health services (CAMHS)
- Child Protection Register (CPR)
- Children and Family Court Advisory and Support Service (Cafcass)
- Children and Young People's Strategic Partnerships (CYPSP)
- Children's Workforce Development Council (CWDC)
- Common Assessment Framework (CAF)
- Criminal Justice Board (CJB)
- Criminal Records Bureau (CRB)
- Crown Prosecution Service (CPS)
- Department for Children, Schools and Families (DCSF)
- Department for Education and Skills (DfES)
- Department of Health (DH)
- Further education (FE)
- HM Prison Service (HMPS)
- Immigration removal centres (IRCs)
- Independent Safeguarding Authority (ISA)
- Independent Schools Inspectorate (ISI)
- Joint area reviews (JARs)
- Juvenile Awareness Staff Programme (JASP)
- Local Government Information Unit (LGIU)
- Local safeguarding children boards (LSCBs)
- Ministry of Defence (MoD)
- Multi-agency public protection arrangements (MAPPA)
- Multi-agency risk assessment conferences (MARAC)
- National College of School Leadership (NCSL)
- National Health Service (NHS)
- National minimum standards (NMS)
- Primary care trust (PCT)
- Prison Service Order (PSO)
- Race equality action teams (REATs)
- Schools Inspection Service (SIS)
- Short-term holding facilities (STHFs)
- SMART recommendations – specific, measurable, achievable, realistic, timely
- Soldiers' Sailors' and Airmen's Families Association (SSAFA)
- Special educational needs (SEN)
- The UK Border Agency (UKBA)
- Witness care units (WCUs)
- Youth Justice Board (YJB)
- Youth Offending Teams (YOTs)

E Appendix E: References

Introduction

1 Children who are in the care of a local authority.

2 The scope of joint area reviews (JARs) includes services for children and young people from birth to 19 years, whether by statutory, voluntary or private providers, which are assessed by any of the inspectorates and commissions listed in section 20 of the Children Act 2004. It also includes services for those over 19 who receive services as care leavers under the Children Act 1989, and those over 19 but under 25 with a learning difficulty. For services provided in prisons and removal centres, by local probation boards and police forces, only services for children up to their 18th birthday are within the scope of JARs. Children Act 2004 functions, on cooperation to improve well-being, information databases, Local Safeguarding Children Boards, children and young people's plans, and directors of and lead members of children's services, are also within the scope of JARs.

3 *Working together to safeguard children*, revised edition, HM Government, 2006.

4 *Working together to safeguard children*, revised edition, HM Government, 2006.

Executive summary

5 * In instances where more than one government department has been identified as having responsibilities in regard to recommendations, a suggested lead department has been named to liaise and coordinate this work.

6 The Children Act 2004 established a statutory duty on relevant agencies to cooperate to promote the well-being of children and young people.

7 *Safeguarding children: the second joint chief inspectors' report on arrangements to safeguard children* (2005) made a similar recommendation in respect of children detained in immigration removal centres. The Government rejected that recommendation as unnecessary since welfare assessments and care planning were already being carried out (see Appendix A, recommendation 10). However, subsequent inspections have found that this is not the case and the recommendation is reiterated accordingly.

Chapter 1: The Safeguarding Framework

8 S14(1) of the Children Act 2004. LSCBs' functions are set out in more detail in *The Local Safeguarding Children Boards regulations 2006*. Under S14(2) additional functions may be given by Secretary of State regulations.

9 *Working together to safeguard children*, revised edition, HM Government, 2006.

10 *Survey of Chairpersons of Local Safeguarding Children Boards*, Ofsted, 2007, www.safeguardingchildren.org.uk

11 *Local safeguarding children boards: a review of progress*, DfES, 2006.

12 The full report is available on the Safeguarding Children website: www.safeguardingchildren.org.uk

13 The Healthcare Commission invites LSCBs to provide information about how each trust contributes to their board. This information was used to cross-check declarations made by trusts about compliance with Core Standard 2 on safeguarding children during the 2006–07 annual health check.

14 As set out in s13(3) of the Children Act 2004: local authority children's services, district councils, police, local probation board, YOT, strategic health authorities (SHA) and PCTs, NHS trusts, Connexions services, Cafcass, secure training centre(s), prison(s) where children are held.

15 Cafcass promotes the welfare of children in family proceedings. These involve care proceedings, adoption arrangements or contact and maintenance arrangements for children whose parents are separated or divorced.

16 The Children Act 2004 required strategic partnerships to be in place in all areas from April 2005 to promote cooperation between agencies to improve the well-being of children in the area.

17 The children and young people's plan is an important element of the Children Act 2004 reforms. All children's area authorities (with the exception of authorities categorised as four star) are required to produce a single, strategic, overarching plan for all services affecting children and young people.

18 Sections 67 and 68 of the Criminal Justice and Court Services Act (2000) first placed these arrangements on a statutory footing. Sections 325–327 of the Criminal Justice Act (2003) re-enacted and strengthened those provisions. In March 2003, the Home Secretary issued statutory guidance to the Responsible Authorities on how they should discharge their MAPPA duties.

19 Offenders may be placed in one of three categories under MAPPA:

- **Category 1** – Registered Sexual Offenders: offenders subject to the notification requirements of Part 2 of the Sexual Offences Act 2003. They may also be subject to notification requirements as a result of a Sexual Offences Prevention Order.
- **Category 2** – Violent Offenders and Other Sexual Offenders: violent offenders who receive a sentence of imprisonment of 12 months or more and those who have committed specific offences against children. It includes those detained under Hospital Orders or Guardianship Orders.
- **Category 3** – Other Dangerous Offenders: offenders who do not meet the criteria under Category 1 or 2, but who have a conviction or caution for a criminal offence which indicates they are capable of causing serious harm to the public **and** are considered by the Responsible Authority to pose a risk of serious harm to the public.

20 Increasing numbers are to be expected. For example, periods of sexual offender registration vary and can last for life. Overall numbers will increase, therefore, as new offenders enter MAPPA and existing offenders continue to be managed.

21 Children's views on recruitment from *Children on care standards: children's views on National Minimum Standards*, Children's Rights Director for England, 2007. A survey of 433 children and young people.

22 *The Bichard Inquiry Report*, Chairman: Sir Michael Bichard, 2004.

23 Under the Safeguarding Vulnerable Groups Act 2006 a new, statutory Independent Safeguarding Authority will have responsibility for taking barring decisions. The CRB will run the application processes for decisions.

24 The Children Act 2004 established a statutory duty on relevant agencies to cooperate to promote the well-being of children and young people.

Chapter 2: The wider safeguarding role of public services

25 S11(2a) of the Children Act 2004.

26 *Staying safe: action plan*, HM Government, 2008.

27 Core standard 2 states that 'Healthcare organisations must protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.' (*Standards for better health*, Department of Health, 2004)

28 *A review of children's hospital services in England*, Healthcare Commission, 2007.

29 *Why children die: a pilot study*, Confidential Enquiry into Maternal and Child Health, May 2008.

30 The TellUs2 survey, carried out in spring 2007, was a survey of children and young people in a sample of schools across England. It asked their views about their local area and included questions covering the five Every Child Matters outcomes.

31 *Children and safeguarding: children's views for the DfES priority review*, Children's Rights Director for England, 2007. A survey of 83 children and young people.

32 National Minimum Standards were introduced in 2002 for children's homes, boarding schools, residential special schools, fostering services and FE colleges. Residential family centres and adoption services followed in 2003 and adoption support agencies in 2006. On 1 April 2007, Ofsted took over responsibility from the Commission for Social Care Inspection for the inspection of children's homes, adoption and fostering services.

33 The Education (Independent School Standards) (England) Regulations 2003.

34 *Better safe than sorry: preventing unintentional injury to children*, Audit Commission and Healthcare Commission, 2007.

35 Between 1995/97 and 2002/04, for children under 15 the death rate fell by 29% and the rate of serious injury by 34%. Source: Department of Health, quoted in *Better safe than sorry*.

36 For each full inspection and each full follow-up inspection, HM Inspectorate of Prisons carries out a voluntary and confidential survey of a representative proportion of the population of young people in the prisons inspected. The most recent published report covered the period 2004–06.

Appendix E: References

37 *Why children die: a pilot study*, Confidential Enquiry into Maternal and Child Health, May 2008.

38 The White Paper *Choosing health*, Department of Health and Department for Education and Skills, 2004, set a target for 75% of all schools to achieve Healthy Schools Status by 2009. Schools must satisfy criteria in four areas: healthy eating, physical activity, personal, social and health education, and emotional health and well-being.

39 Office for National Statistics and Teenage Pregnancy Unit, 2007, DCSF.

40 *Statistics on drug misuse: England 2007*, The Information Centre, 2007.

41 Cited in *Staying safe: action plan*, HM Government, 2008.

42 *Pushed into the shadows: young people's experience of adult mental health facilities*, Children's Commissioner for England, 2007.

43 For 2008–09, the Government will measure the percentage of PCTs and local authorities which together provide a comprehensive CAMHS service for their area, as set out in *PSA delivery agreement 12: improve the health and well-being of children and young people*, HM Government, 2007.

44 Joint inspection work by HMI Constabulary (HMIC) and HM Crown Prosecution Service Inspectorate (HMCPSI) assessed the role of the police service and Crown Prosecution Service in this area. *Violence at home: a joint inspection of the investigation and prosecution of cases involving domestic violence*, HMCPSI and HMIC, 2004.

45 Under the Crime and Disorder Act 1998.

46 Domestic violence is termed 'domestic abuse' in the police service.

47 'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners and family members, regardless of gender and sexuality.' Updated draft ACPO guidance.

48 *Domestic violence, safety and family proceedings*, HM Inspectorate of Court Administration, 2005.

49 *Children on bullying: a children's views report,* Children's Rights Director for England, 2008. A survey of the views of 319 children and young people at a Children's Rights event, including children living in children's homes or in foster care, children living at home and receiving help from social services and children at boarding schools and FE colleges. One hundred and fifty-eight children took part in discussion groups, while 161 completed question cards.

50 HMIP Inspectorate research.

Chapter 3: Safeguarding groups of vulnerable children

51 *The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2006/07*, Ofsted, 2007.

52 *Placements, decisions and reviews: a children's views report*, Children's Rights Director for England, 2006. Views of 86 children and young people.

53 *About social workers: a children's views report*, Children's Rights Director for England, 2006. Views of 593 children and young people.

54 *The state of social care in England 2006–07*, Commission for Social Care Inspection, 2008.

55 *The state of social care in England 2006–07*, Commission for Social Care Inspection, 2008.

56 *Young people's views on leaving care: what young people in, and formerly in, residential and foster care think about leaving care*, Children's Rights Director for England, 2006. A survey of 208 young people.

57 *Running away: a children's views report*, Children's Rights Director for England, 2006.

58 *Children's views on standards: a children's views report*, Children's Rights Director for England, 2006.

59 Public law cases are those where a local authority makes an application to court under the Children Act 1989. Cafcass is required by legislation to provide a children's guardian who is a qualified and experienced social worker.

60 *Children's guardians and care proceedings*, HM Inspectorate of Court Administration, 2007.

61 *Children and young people – CPS policy on prosecuting criminal cases involving children and young people as victims and witnesses*, CPS, 2006.

62 *Direct communication with victims: an audit of CPS performance in relation to keeping victims informed*, HM Crown Prosecution Service Inspectorate, 2007.

63 *Valuing victims and witnesses*, HM Inspectorate of Court Administration, 2005.

64 *Youth Justice Annual Statistics 2005–06*, Youth Justice Board.

65 The Government's Persistent Young Offender Pledge, announced in 1997, states that the time between arrest and conviction should be less than 71 days. The pledge defines Persistent Young Offenders as young people aged 10–17 who have been convicted of a recordable offence on three or more occasions and commit another offence within three years. The pledge is shared jointly by all criminal justice departments and agencies, with the lead responsibility for national delivery being the Office for Criminal Justice Reform, and at a local level the Local CJB.

66 *HMICA thematic inspection of youth courts: implementation of the Youth Court Good Practice Guide (2001)*, HM Inspectorate of Court Administration, 2007.

67 *Let's talk about it – a review of healthcare in the community for young people who offend*, Healthcare Commission and HMI Probation, 2006.

68 PSO4950, *The care and management of young people*, HM Prison Service, revised 2007.

69 *Standards for better health*, Department of Health, 2004

70 *Improving services for children in hospital*, Healthcare Commission, 2007.

71 *Why children die: a pilot study*, Confidential Enquiry into Maternal and Child Health, May 2008.

72 *A life like no other: a national audit of specialist inpatient healthcare services for people with learning difficulties in England*, Healthcare Commission, 2007.

73 *State of social care in England 2006–07: Annexes*, Commission for Social Care Inspection, 2008.

74 The UK Border Agency (UKBA) replaced the former Border and Immigration Agency in April 2008.

75 UKBA, www.bia.homeoffice.gov.uk/asylum

76 S21 of the UK Borders Act 2007 requires the Home Secretary to issue such a Code of Practice.

77 *Better outcomes: the way forward. Improving the care of unaccompanied asylum seeking children*, Border and Immigration Agency, 2007.

78 *Asylum statistics United Kingdom 2006*, Home Office, 2007.

79 *Children looked after by local authorities – year ending 31 March 2006*, DCSF, 29 March 2007. Based on data returns from local authorities.

80 The Hillingdon judgement (R (Behre and others) v Hillingdon LBC [2003] EWHC 2075 (Admin)) confirmed that UASC under 18 should be accommodated as looked after children under s20 of the Children Act 1989.

81 *Unaccompanied asylum seeking children leaving care costs 2007–08 guidance*, DSCF, 2007.

Appendix E: References

82 Some children and their families are transferred between centres or temporarily re-admitted into the community and taken back into detention later.

83 Under a new agreement, Ofsted and the Ministry of Defence will work in partnership to ensure that recruits and military trainees experience high quality training, with appropriate awareness of welfare and care in the UK's armed services. Ofsted will take over responsibility for carrying out independent inspections in education and training for 2008–09. This will build on the work previously carried out by the Adult Learning Inspectorate and assess progress in addressing issues raised in previous inspections.

84 *The second joint chief inspectors' report on arrangements to safeguard children* (2005) made a similar recommendation in respect of children detained in immigration removal centres. The Government rejected that recommendation as unnecessary since welfare assessments and care planning were already being carried out (see Appendix A, recommendation 10). However, subsequent inspections have found that this is not the case and the recommendation is reiterated accordingly.

Chapter 4: Child protection

85 Under s17(1)(a) & (b) of the Children Act 1989.

86 *Victoria Climbié inquiry report*, Lord Laming, 2003.

87 *Working together to safeguard children*, revised edition, HM Government, 2006.

88 *Victoria Climbié inquiry report*, Lord Laming, 2003.

89 *The Bichard Inquiry Report*, Chairman: Sir Michael Bichard, 2004.

90 *Improving services for children in hospital*, Healthcare Commission, 2007.

91 *The care and management of young people*, PSO4950, HM Prison Service, revised 2007.

92 The most recent reports are: *Improving safeguarding practice: study of serious case reviews 2001–2003* and *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–05*, DCSF, January 2008.

93 SMART: Specific, Measurable, Achievable, Realistic, Timely.

94 The Healthcare Commission invites LSCBs to provide information about how each trust contributes to their board. This information was used to cross-check declarations made by trusts about compliance with Core Standard 2 on safeguarding children during the 2006–07 annual health check.

95 *Safeguarding children and young people: a shared responsibility*, Healthcare Commission, 2007, cited on pp 28–29.

96 Children defined as being 'in need' under s17 of the Children Act 1989 are those whose vulnerability is such that they are at risk of not achieving a satisfactory level of health or development without the provision of services.

97 Assessments carried out under s47 of the Children Act 1989 to determine any significant unmet needs for children and families.

98 Since 2005 1,224 children and young people aged 10–17 have responded to a computer based survey (using Viewpoint) ran by YOTs to gain their views about being involved with the youth justice services.

99 The guidance describes this as 'A broad term used to describe all those children at risk of poor outcomes in relation to the five outcome areas defined in *Every Child Matters*.' *Common Assessment Framework for children and young people: managers' guide* (DCSF, 2007).

[100] *Children's consultation on the children's index*, Children's Rights Director for England, 2007. A survey of 113 children and young people.

[101] The YJB describes Asset as 'a common structured framework for assessment of all young people involved in the criminal justice system. It is a standard assessment of the factors contributing to a young person's offending. Asset should be completed at the beginning and end of all interventions and at the mid-point of Detention and Training Orders.'

[102] *Confidentiality: protecting and providing information*, General Medical Council, 2004.

[103] *Improving hospital services for children*, Healthcare Commission, 2007.

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