

An Inspection of the work of Probation Trusts and Youth Offending Teams to protect children and young people

*An inspection by
HM Inspectorate of Probation*

August 2014

An Inspection of the work of Probation Trusts and Youth Offending Teams to protect children and young people

An Inspection by HM Inspectorate of Probation

August 2014

Acknowledgements

We would like to thank all those who took part in this inspection and the pilot inspections; without their cooperation the inspection would not have been possible.

We would like, in particular, to thank the Youth Offending Teams in Bath & North East Somerset, Bromley, Calderdale, Derbyshire, Flintshire, Nottingham City, and Reading along with the corresponding children's services departments and the Probation Trusts and Police Forces in Avon & Somerset, Derbyshire, London, Nottinghamshire, North Wales, Thames Valley and West Yorkshire.

This inspection formed part of HM Inspectorate of Probation's programme of inspections of Probation Trusts and Youth Offending Teams for 2013-2014. We are grateful for the additional assistance provided by our colleagues from the Care and Social Services Inspectorate Wales, HM Inspectorate of Constabulary, the National Society for the Prevention of Cruelty to Children and Ofsted in carrying out this inspection.

Lead Inspector	Jane Attwood, <i>HMI Probation</i>
Deputy Lead Inspector	Tony Rolley, <i>HMI Probation</i>
Inspection Team	Lisa Clarke, <i>HMI Probation</i> Keith Redfern Humphreys, <i>HMI Probation</i> Iolo Madoc-Jones, <i>HMI Probation</i> Avtar Singh, <i>HMI Probation</i> Paul Eveleigh, <i>HMI Constabulary</i> Mark Ewan, <i>HMI Constabulary</i> Martine Moore, <i>HMI Constabulary</i> Neil Wain, <i>HMI Constabulary</i> Bobbie Jones, <i>Care and Social Services Inspectorate Wales (CSSIW)</i> Iain McKay, <i>National Society for the Prevention of Cruelty to Children (NSPCC)</i> James McParland, <i>Ofsted</i>
HMI Probation Support Services	Pippa Bennett, <i>Support Services Manager (Information and Operations)</i> Adam Harvey, <i>Support Services Officer (Information and Operations)</i> Jo Hewitt, <i>Support Services Officer (Information and Operations)</i> Oliver Kenton, <i>Assistant Research Officer</i> Lynne Osborn, <i>Support Services Officer (information and Operations)</i> Alex Pentecost, <i>Support Services Manager (Communications)</i>
Assistant Chief Inspector	Andy Smith, <i>HMI Probation</i>

Please note – all names referred to in the practice examples have been amended to protect the individual's identity.

Foreword

Staff working in both probation and youth offending services have a crucial role to play, alongside other agencies, in protecting children and young people. They also have a key role in managing offenders who pose a risk to children and young people.

Overall, we found that staff took their responsibilities seriously and we found a number of examples of good practice where it was clear that their contribution had been well thought through and was effective. However, for many, work to protect children and young people was not viewed as a core task. In addition, in the organisations we visited, systems to manage the identification and referral of children and young people who were at risk were not robust enough for us to be confident that all steps had been taken to protect children and young people in every case. We also found shortcomings in the management oversight and direction of practice. More needed to be done by managers to rectify these deficiencies and in particular, there is a need for leadership in making clear to all staff what role they play in contributing to the protection of children and young people.

The protection of children and young people is not the sole responsibility of any one organisation. Too much work took place in isolated organisational 'silos'. We found that often where there was a need for joint working with other agencies, for example in exchanging information and making assessments, this had not happened. If arrangements to protect children and young people are to work properly, senior managers in probation and youth offending services need to engage effectively at a strategic level with other agencies. If they do so, it is more likely that effective practice will be developed and implemented, and mutual understanding of the roles played by all the agencies involved in protecting children and young people will grow.

We publish this report before the planned introduction of the integrated inspections of services for children and young people in need of help and protection. We strongly support the principle of joint inspection and will be a partner in these inspections. In our core inspections of work in probation services and Youth Offending Teams we will also continue to focus on the protection of children and young people. The recommendations in this report are intended to make the outcome of effective protection of children more likely in every relevant case.



Paul McDowell

HM Chief Inspector of Probation

August 2014

Contents

Acknowledgements	2
Foreword	3
Summary of findings	5
1. Scope and Purpose	11
2. Work by Probation Trusts to protect children and young people	17
3. Work by Youth Offending Teams to protect children and young people	29
4. Management and leadership	41
Appendix 1: Glossary	47
Appendix 2: Role of the inspectorate and code of practice	49
Appendix 3: References	50
Appendix 4: An example of a Safeguarding Children Checklist	51

Summary of findings

The inspection

This inspection was undertaken by Her Majesty's Inspectorate of Probation in response to the findings from our mainstream inspection programmes of probation and youth offending work practice which suggested that work to protect children and young people carried out by Probation Trusts and Youth Offending Teams (YOTs) was not being consistently delivered well enough.

The inspection focused on the work to identify those children and young people at risk of harm and to take appropriate action where necessary. We visited six Probation Trusts and YOTs to assess the quality of the work by inspecting cases and interviewing offender/case managers. In all we inspected:

- 58 orders held by Probation Trusts and 83 orders held by YOTs which had commenced in the three month period prior to the inspection
- 42 cases in Probation Trusts and 36 cases in YOTs where a child protection plan was or had been in place at some point during the course of the order
- 48 referrals to children's social care services made by Probation Trusts and 37 made by YOTs.

We also interviewed key managers, staff and partners at local and national level involved in work to protect children.

Context

The inspection took place before the reorganisation of Probation Trusts into the National Probation Service and Community Rehabilitation Companies, as part of the Government's *Transforming Rehabilitation* strategy. Our findings in respect of adult offenders therefore relate to Probation Trusts. We believe, however, that as both the National Probation Service and the Community Rehabilitation Companies will manage cases where there are child protection concerns, our findings have relevance to all providers of probation services in the future.

Staff working in probation services supervise adult offenders. They are primarily engaged in work to reduce offending behaviour and protect the public and, as a result of the latter, have a duty to protect children and young people; however, this cannot be done alone. Probation services have their own agency's child protection procedures, but their work with offenders to protect children and young people must be located within wider, joint work. It needs to be facilitated and enabled by children's social care services as well as informed by the police and other agencies. We looked at both the internal, single agency work of Probation Trusts and their joint work with children's social care services and the police.

YOTs work directly with children and young people who have offended or are at risk of offending and their parents/carers. YOT practice to protect children and young people is located within wider, joint work and again needs to be facilitated and enabled by children's social care services as well as informed by other partnership agencies working with the family. We inspected both the direct work with children and young people and the joint work with other agencies, in particular children's social care services.

Overall findings

Work to protect children and young people by Probation Trusts

Systems were in place to identify those children and young people at risk of harm from offenders, and to assess, plan and contribute to joint work to protect them. Policies were not always followed however, and the systems were not always consistently operated. Management oversight was not systematic or effective.

Whilst there was some good work by individual offender managers to contribute to child protection work, the quality of practice varied considerably both across, and within, Trusts. There was little joint planning or work with other agencies. Not all probation staff fully understood the purpose of the work or their role in it; this was particularly apparent where there were children and young people who witnessed domestic violence. Conversely, the role of probation staff was not always well understood by children's social care staff, including the chairs of child protection case conferences and core groups, nor was their expertise always recognised or their potential contribution explored.

Work to protect children and young people by Youth Offending Teams

YOTs were generally well connected to children's social care services and necessary enquiries and referrals were made and information was shared.

There was assessment and planning by YOT staff to help to protect children and young people where necessary, however, it was not consistently of sufficient quality. Parents/carers were not always involved and home visits were not always undertaken. There was little joint assessment and planning by the agencies working with the child or young person.

There was some excellent and imaginative direct work with children and young people and their parents/carers and some good partnership work. Again, the role of YOT staff was not always well understood by children's social care staff, and as a result their contribution was not integrated into joint child protection work. Work to combat child sexual exploitation was being developed in partnership with other agencies.

Management oversight systems were in place, but were not always effective.

Management and leadership

Safeguarding work within Probation Trusts was not always a priority for strategic managers and the impact of Probation Trusts on the work of Local Safeguarding Children Boards was not always clear. We saw little evidence of any challenge by Local Safeguarding Children Board members to improve this.

The contribution of YOTs to the work of Local Safeguarding Children Boards varied. It was not obvious how safeguarding outcomes for children and young people who have offended were improved through the work of the boards. Effective links between Local Safeguarding Children Boards and YOT Management Boards were not always in place and so the strategic oversight of the protection of children and young people who have offended was not coordinated.

Local Safeguarding Children Boards were at various stages of attempting to develop outcome measures to drive forward improvement, however, they had given little attention to the work of Probation Trusts or YOTs.

Specific findings

Work to protect children and young people by Probation Trusts

Probation Trusts had policies and procedures in place to work with offenders who posed a risk to children and young people and to work in partnership to contribute to wider work to protect children and young people. There were processes to identify children and young people linked to offenders, checks were made with children's social care services and referrals were made where a child or young person was recognised as being at risk of harm.

Assessments did not always take into account information from children's social care services, however, and there was no joint assessment or planning. Offender managers did contribute to multi-agency meetings but the quality of that contribution varied. The quality of probation work to protect children and young people also varied considerably, both across, and within, Probation Trusts and offender managers did not always fully understand their role. Probation management information was not easily accessible and management oversight of this area of work was not systematic.

Staff from children's social care services did not always facilitate good information sharing and chairs of multi-agency meetings did not always encourage joint work. The role of offender managers was not always understood or valued by other agencies.

The contribution of Probation Trusts to the Local Safeguarding Children Board was not always effective and the board did not explore or challenge the contribution. Outcome data to Local Safeguarding Children Boards was focused on children's social care service's processes, and did not promote exploration of the impact of joint work to improve outcomes.

National Offender Management Service guidance to Probation Trusts had not been updated to include *Working Together to Safeguard Children 2013*¹ or the equivalent guidance applicable in Wales.

Work to protect children and young people by Youth Offending Teams

YOTs had systems in place to check if children and young people were known to children's social care services and referrals were made where a risk of harm to children and young people was identified.

Assessment and planning had been carried out by YOT staff to help to protect children and young people where necessary, however, it was not always of sufficient quality. Parents/carers were not routinely involved and home visits were not consistently undertaken. Police intelligence to assist assessment and planning by YOT staff was not always accessed or used.

Screenings to assess the vulnerability of children and young people did not pull together all the factors identified in the assessment, and vulnerability management plans were not action focused, did not make reference to parents/carers and were not integrated with child protection plans. There was little joint assessment and planning and children's social care services did not always facilitate good information sharing or encourage joint work.

There was, however, some excellent and imaginative direct work by YOTs with children and young people and their parents/carers and some good partnership work. Work to combat child sexual exploitation was being developed.

Operational management oversight systems were in place but were not always effective. Strategically, effective links between Local Safeguarding Children Boards and YOT Management Boards were not in place.

1 *Working Together to Safeguard Children* A guide to inter-agency working to safeguard and promote the welfare of children, March 2013, Department for Education

Conclusion

Whilst systems were in place to identify children and young people at risk from adult offenders, the work of Probation Trusts was largely process oriented. Offender managers, probation operational and strategic managers and the staff of other agencies, in particular children's social care services, were not always clear about the role of probation services and their contribution to the protection of children and young people. Work was often confined to information sharing rather than effective joint intervention and this potentially left children and young people not fully protected.

YOTs also had systems in place to identify children and young people at risk of harm, assess their vulnerability and plan to protect them where necessary, although the quality varied. Whilst there was some excellent direct work with children and young people, this was sometimes carried out in isolation as opposed to being part of a coherent, multi-agency response, again potentially leaving gaps in protection.

The lead agency for the protection of children and young people, children's social care services did not always facilitate or encourage effective joint work.

Recommendations

The Chief Executive Officer of the National Offender Management Service should:

- issue detailed guidance on the roles and responsibilities of staff in the newly formed National Probation Service and the Community Rehabilitation Companies in relation to protecting children and young people
- ensure all staff understand their contribution to protecting children and young people, in particular those at risk from the emotional impact of witnessing domestic violence.

The Director of Probation and Contracted Services, the Director of the National Offender Management Service in Wales and the Chief Executives of the Community Rehabilitation Companies should:

- ensure staff work **together** with other relevant agencies to assess, plan and intervene to protect children and young people
- establish processes to effectively manage and quality assure work to protect children and young people
- demonstrate a positive impact on the work of the Local Safeguarding Children Board to protect children and young people from adults who pose a risk of harm to them.

Youth Offending Team managers should:

- ensure staff work **together** with other relevant agencies to assess, plan and intervene to protect children and young people
- involve parents/carers where appropriate in the protection of children and young people
- ensure that police intelligence is used effectively in joint work to protect children and young people
- demonstrate an improvement in safeguarding outcomes for children and young people who have offended through their contribution to the work of the Local Safeguarding Children Board.

Representatives of probation services and Youth Offending Teams on Local Safeguarding Children Boards should work with other board members to:

- ensure that multi-agency arrangements for information sharing work effectively and consistently
- establish and monitor outcome data that demonstrates effective **joint** working to safeguard children and young people
- promote better understanding across social care staff of the roles and responsibilities of probation and YOT staff.

Scope and Purpose

1

1. Scope and Purpose

Summary

This chapter provides the background to the inspection, and gives a summary of the legislative framework and practice guidance in relation to work to protect children and young people within Probation Trusts and YOTs. It also sets out how the inspection structure and methodology were developed, and gives information about the people we interviewed and a profile of the cases we inspected.

Key facts

- The catalyst for this inspection was the findings from our mainstream inspection programmes of Probation Trusts and YOTs, and the pilots of the joint inspection of the multi-agency arrangements for the protection of children in early 2013 led by Ofsted. All suggested that this work was not consistently delivered well enough.
- We inspected cases held by Probation Trusts and YOTs where there was a child protection component. We also examined referrals made by the two agencies to children's social care services.
- The legislative framework for the contribution of Probation Trusts and YOTs to the protection of children and young people is contained within *Working Together to Safeguard Children 2013* and the equivalent guidance applicable in Wales.
- Guidance from the National Offender Management Service (NOMS) is contained within *Safeguarding Children – Checklist for Offender Managers*² issued in 2009 by the Public Protection Unit.
- Guidance from the Youth Justice Board (YJB) on assessing vulnerability is contained within *Case Management Guidance*³ and *National Standards 2013*⁴.

Background to the inspection

- 1.1. The findings from the HM Inspectorate of Probation youth offending inspection programme which ran for three years until 2012 gave us cause to consider further inspection into this area of work. In the Core Case Inspection of youth offending work, we found that overall, a third of the work to safeguard children and young people was of insufficient quality. The finding so far, from the Short Quality Screenings and the Full Joint Inspections under the current programme of youth offending work, is that this still remains the case.
- 1.2. In our Offender Management Inspection programme of adult offending work which assessed the quality of work carried out by Probation Trusts, we found that the risk of harm to children and young people had not been accurately reflected in the assessment in a fifth of cases. In nearly a third there had been no effective probation contribution to multi-agency child protection procedures and there was management involvement in only half of the cases involving child safeguarding issues.
- 1.3. In June 2010, the Education Secretary commissioned an independent review of the child protection system in England, led by Professor Eileen Munro. The Munro Review of Child Protection⁵ published its final report in May 2011 and made 15 recommendations to Government including a revised inspection framework for protecting children and young people. Following this, Ofsted introduced a framework for the inspection of multi-agency child protection arrangements and three pilot inspections were carried out in December 2012, January and February 2013.

2 Safeguarding Children – Checklist for Offender Managers NOMS Public Protection Unit 2009

3 Case Management Guidance YJB 2013

4 National Standards for Youth Justice Services YJB 2013

5 The Munro Review of Child Protection: Final Report Department for Education 2011

- 1.4. HM Inspectorate (HMI) of Probation was closely involved with the pilots specifically looking at the contributions of Probation Trusts and YOTs. Following the postponement of the launch of the main programme of inspections we decided that we should carry out a thematic inspection of child protection practice in six Probation Trusts and YOTs.

The legislative framework and guidance

- 1.5. Under the *Children Act 1989 (amended 2004)*⁶, local authorities are required to safeguard and promote the welfare of children; these duties are discharged through local authority children's social care services and other agencies have a duty to cooperate with the work.
- 1.6. England and Wales share primary legislation in relation to the welfare and protection of children and young people, however, the guidance, although similar, is expressed slightly differently in Wales.
- 1.7. The guidance *Working Together to Safeguard Children 2013* details the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and young people.

'Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. Once identified children's social care services should assess the needs of children and where a child and family would benefit from coordinated support from more than one agency (e.g. education, health, housing, police) there should be an inter-agency assessment. These early help assessments, such as the use of the Common Assessment Framework (CAF), should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989 (2004).'

'Where there are more complex needs, help may be provided under section 17 of the Children Act 1989 (children in need). Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989.'

- 1.8. In Wales the applicable guidance published by the Welsh Government is entitled: *Safeguarding Children: Working Together under the Children Act 2004*.
- 1.9. Following initial assessment(s) the decision to make a child or young person the subject of a child protection plan is taken at an Initial Child Protection Conference (ICPC) where a plan is formulated and a core group of professionals involved with the child is chosen to take the plan forward.
- 1.10. Probation Trusts and YOTs are both subject to Section 11 of the Children Act 2004 which places duties on them:

'To ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.'

6 The Munro Review of Child Protection: Final Report Department for Education 2011

7 Safeguarding Children: Working Together under the Children Act 2004 Welsh Assembly Government 2007

Within *Working Together to Safeguard Children 2013* Probation Trusts are described as being:

'Primarily responsible for providing reports for courts and working with adult offenders both in the community and in the transition from custody to community to reduce their reoffending. They are, therefore, well placed to identify offenders who pose a risk of harm to children as well as children who may be at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour and of other poor outcomes due to the offending behaviour of their parent/carer(s).'

And they are tasked:

'Where an adult offender is assessed as presenting a risk of serious harm to children, the offender manager should develop a risk management plan and supervision plan that contains a specific objective to manage and reduce the risk of harm to children.'

'In preparing a sentence plan, offender managers should consider how planned interventions might bear on parental responsibilities and whether the planned interventions could contribute to improved outcomes for children known to be in an existing relationship with the offender.'

- 1.11. Guidance from NOMS on probation work to protect children and young people was issued in 2009. To fulfil their duties offender managers should:
- carry out assessments of the risk of harm posed to children and young people
 - refer to children's social care services where necessary
 - put in place plans to protect those identified as being at risk from the offender
 - work directly with the offender to reduce the risk of harm posed and protect victims or potential victims
 - contribute to the assessments and plans of other agencies
 - contribute and coordinate their work with other agencies to protect children and young people
 - share relevant information
- 1.12. In June 2014 Probation Trusts were replaced by the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs). The requirements of *Working Together to Safeguard Children 2013* will apply to the new organisations.
- 1.13. Within *Working Together to Safeguard Children 2013* YOTs are described as being:

'Responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. They are therefore well placed to identify children known to relevant organisations as being most at risk of offending and to undertake work to prevent them offending. YOTs should have a lead officer responsible for ensuring safeguarding is at the forefront of their business.'

- 1.14. YOTs work directly with children and young people and so the role of case managers may be more integrated with wider children's social care services. To fulfil their duties case managers (and/or other YOT workers):
- carry out assessments of the vulnerability and safeguarding needs of children and young people
 - refer to children's social care services where necessary
 - put in place plans to protect children and young people
 - work face-to-face with children and young people and their parent/carers to protect them
 - contribute to the assessments and plans of other agencies
 - contribute to and coordinate their work with other agencies
 - share relevant information
- 1.15. Police officers are seconded to work within YOTs and are vital members of staff. Their role varies and was reviewed in 2010⁸ by the Association of Chief Police Officers (ACPO) and the YJB which made recommendations for an 'enhanced' role specifically including the use and sharing of intelligence. In June 2014 the YJB issued updated guidance on this subject.
- 1.16. Most importantly, Working Together to Safeguard Children 2013 is clear about the need for the work to protect children and young people to be carried out jointly:

"Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children."

- 1.17. Local Safeguarding Children Boards (LSCBs) were established by the *Children Act 2004* which placed a statutory responsibility on each locality to have a board in place. LSCBs bring agencies together, including Probation Trusts and YOTs. Boards are the key local mechanism for ensuring that services work together to safeguard and promote the welfare of children and young people. The LSCB partnership members should cooperate, hold each other to account and ensure that safeguarding children and young people remains high on the agenda across their area.

Scope and methodology

- 1.18. The purpose of the inspection was to assess the effectiveness of the work of Probation Trusts and YOTs in contributing to the protection of children and young people from harm. Specifically, we wanted to assess:
- whether the Probation Trust/YOT were identifying children and young people who were at risk of harm, making the appropriate assessments and referrals, and taking action where necessary
 - the quality and timing of referrals to children's social care services and the quality and timing of the response by children's social care services
 - the quality of the contribution made by Probation Trusts and YOTs to protect children and young people
 - the work by children's social care services to promote effective joint working with children and young people who were subject to formal child protection plans and were being supervised by a

8 <http://www.justice.gov.uk/downloads/youth-justice/monitoring-performance/yot-management-board-guidance-consultation/yot-police-officer-role.pdf>

YOT or were connected to an offender known to Probation Trusts

- the effectiveness of operational oversight of cases involving the protection of children and young people, the leadership and management arrangements and the strategic approach to management of child protection procedures and partnership working.
- 1.19. A pilot inspection in Derbyshire YOT and Derbyshire Probation Trust to test out the methodology was carried out in July 2013.
- 1.20. Inspection fieldwork was completed between September and November 2013 in YOTs and children's social care services based in: Bath & North East Somerset, Bromley, Calderdale, Flintshire, Nottingham City, and Reading; and the corresponding Probation Trusts and Police Forces in Avon & Somerset, London, Nottinghamshire, North Wales, Thames Valley and West Yorkshire.
- 1.21. We made judgements against criteria which included:
- identification of child protection issues
 - assessment
 - referral to relevant agencies
 - action taken to protect children and young people
 - information sharing
 - joint work with other agencies involved
 - operational management oversight of practice
 - contribution of leadership and management to the protection of children and young people.
- 1.22. In order to assess whether children and young people who might be at risk of harm had been identified and appropriate action taken, we inspected 58 cases held by Probation Trusts and 83 cases held by YOTs which had commenced during the three month period prior to the inspection.
- 1.23. In order to assess the contribution of the Probation Trusts/YOTs to child protection work we assessed 42 Probation Trust and 36 YOT cases where a child protection plan had been in place at some point during the order.
- 1.24. We also assessed 48 referrals to children's social care services made by Probation Trusts and 37 made by YOTs to assess the quality and timing of referrals and the quality and timing of the response.
- 1.25. Where the children or young people in our inspection sample were also known to children's social care services, inspectors from Ofsted, and CCSIW (in Wales), examined case files to assess the work by children's social care services to promote effective joint working. HM Inspectorate of Constabulary inspectors reviewed police records to assess information sharing and joint working by police officers.
- 1.26. We interviewed operational and strategic managers and LSCB members and looked at minutes of meetings, policies and procedures, performance data, training records and other relevant information provided by the Probation Trusts and YOTs.

**Work by
Probation
Trusts to
protect children
and young
people**

2

2. Work by Probation Trusts to protect children and young people

Summary

This chapter describes the work of Probation Trusts with offenders who pose a risk of harm to children and young people (or may be in contact with children and young people who are in need of protection) and their contribution to the joint work to protect them. It includes identification, assessment, planning and action to protect, as well as information sharing and management oversight. It also evaluates how well children's social care services facilitated joint work.

Key findings

- There were processes in place to identify children and young people linked to offenders and checks were made with children's social care services, but these processes and systems were not always robust or comprehensive.
- Child protection concerns were not always identified by probation staff.
- Referrals to children's social care services where a child or young person was recognised as being at risk of harm, often lacked detail, and systems for recording and tracking responses to referrals were poor.
- There was no joint assessment or planning with other agencies in relation to child protection issues.
- The quality of probation work to protect children and young people varied considerably both across and within Probation Trusts, and staff were often unsure of their role.
- Children's social care services did not always facilitate good information sharing and/or joint work and chairs of multi-agency child protection meetings did not always encourage joint work.
- Management oversight of this area of work was not systematic or consistently effective.

Identification of children and young people who might be at risk from an offender

- 2.1. Probation staff can come into initial contact with offenders at a variety of stages in the criminal justice process. An offender manager meets the offender at the pre-sentence stage if a pre-sentence report (PSR) is required by the court. Alternatively, there may be little contact until after sentencing or on release from custody. In some circumstances, little may be known about the offender. Offender managers should therefore ask offenders at the earliest possible stage if they have, or are likely to have, contact with children or young people. They should then make enquiries with children's social care services to both verify the information and check whether anything is known about any identified children or young people. Where the offender is involved with children or young people, an assessment should be carried out to determine if they pose a risk of harm to them. Plans should be put in place to protect children and young people if necessary, information shared, and an appropriate contribution made to the work of other agencies.
- 2.2. To enable us to ascertain whether Probation Trusts were making sufficient initial checks about an offender's contact with children or young people, we inspected 58 randomly selected cases opened in the three months prior to the inspection fieldwork. We were looking to see:
 - if the offender manager had checked whether there was any regular contact with children and

young people or any contact being sought and, where this was the case, that full details had been obtained (names, addresses and dates of birth) and checks made with children's social care services

- whether the necessary notification of probation involvement was communicated in those cases where children's social care services were involved
 - that referrals were made to children's social care services where appropriate
 - that all necessary action was taken to protect children and young people.
- 2.3. There was considerable variation across the Trusts we inspected in their initial procedures to screen offenders, identify children and young people, make checks and take action where necessary. Some used what they described as 'known adult' checks where they sent the name and address of every offender to children's social care services. We were unable to assure ourselves that this was always a robust system as children's social care services generally stored data based on the child or young person's name not that of the adult. It was possible therefore that Probation Trusts (and the corresponding children's social care services) thought they had shared information when, in fact, they had not.
- 2.4. Other Trusts only made enquiries where offenders revealed that they had contact with children and young people; the names of children or young people identified by the offender were then checked. Some Trusts were checking at the PSR stage whilst others checked at the commencement of a court order. In Nottinghamshire, we were pleased to see that the procedure extended to subsequent further checks where a significant event had taken place in the course of the order.
- 2.5. In some places, administrators took responsibility for initial checks, in others it was done by offender managers. In London, in the Southwark office, there was access to the children's social care database to enable checks to be made directly.
- 2.6. Not all children's social care services had secure email addresses which sometimes hampered the communication of full details with Probation Trusts. Some processes were inherently weak. For example, where the Probation Trust requested a response **only** if the names were known to children's social care services. There was no way for the Trust to know if a lack of response meant that the name was not known or that the enquiry had not been carried out.
- 2.7. Some Trusts had made efforts to bolster their processes. London Probation Trust used a checklist to obtain details of any contact with children and young people at the PSR stage. The subsequent check with children's social care services, contained within the same document, also served as notification of probation involvement (Appendix 4).
- 2.8. The misspelling of names also occurred in more than one Trust with the potential for information to be missed. In one Trust, we saw the same child referred to in probation records by three similar but different first names.
- 2.9. Of the cases we inspected, sufficient enquiries about relationships or involvement with children and young people had been made in just over half (although in Flintshire and in London the proportions where enquiries were made was higher). In the remaining cases, offender managers had not made sufficient enquiries to ascertain whether there was any involvement with children and young people.
- 2.10. Where questions to the offender had revealed contact or a relationship with a child or young person, subsequent enquiries with children's social care services were not made in all cases and in two of the Trusts, there was no evidence that enquiries had been carried out at all. In some, there was a lack of thoroughness. For example, a woman revealed that she had four children, said that all were in care and that she had no contact with them. This information was not verified with children's social care services.

- 2.11. Where enquiries revealed that children's social care services were working with the children or young people, the offender manager had not sent a notification of probation involvement in nearly half of relevant cases.
- 2.12. Conversely, there were examples of good practice where offender managers had demonstrated appropriate professional curiosity and made extra checks. In Avon & Somerset we saw a case where there had been numerous previous referrals by different agencies about a family but no action had been taken. The offender manager then shared information about the drug use of the offender and worked jointly with children's social care to ensure that a strategy meeting was called. The children were ultimately placed on a child protection plan. In Nottingham we also saw an offender manager make rigorous checks on an offender who was subject to community order with just an unpaid work requirement.

Good practice example: initial checks with children's social care services

Mr Yousef had a history of violence, drunkenness and theft. He was convicted of theft. The offender manager established that he had two young children who lived with his estranged partner. Checks revealed domestic violence call outs to the police at her address and that the children were known to children's social care services. Children's social care services were then notified of probation involvement and a full assessment of risk to the children was carried out. **(Nottinghamshire Probation Trust)**

- 2.13. In a third of relevant cases, for example those of domestic violence, checks with the police had not been carried out. Again this hid distinct variations across the trusts - in Thames Valley and Avon & Somerset, police checks were made in all cases.
- 2.14. Where we judged that child protection issues existed, they had not been recognised at all in over a third of the randomly selected cases, and of eight which should have been brought to the attention of children's social care services, five had not been. In a small number of cases where risks relating to the protection of identified children and young people were known, risks to other children and young people had not been considered. Where children or young people were not identified at this stage, or risks to them were not recognised, subsequent reviews of the case had rarely rectified the situation.

Children and young people already on child protection plans

- 2.15. We asked Probation Trusts to identify cases where the offender had some sort of connection to a child or young person who was the subject of a plan. For example he may have been the father of the child or the partner of someone with children on child protection plans. In these cases we were looking to see if the appropriate contribution had been made by the Probation Trust to the protection of the child or young person.
- 2.16. It was a matter of concern that in some Trusts the identification of these cases proved to be inaccurate and in most it proved difficult. 'Warning flags' related to child protection on nDelius (the national probation database) were not always used correctly or consistently, even within Trusts. Not all arrangements could accurately differentiate between offenders who posed a risk of harm to 'unspecified' children and young people, and those who were involved with known children and young people on child protection plans.
- 2.17. Children and young people are made subject to child protection plans for a variety of reasons. It is not always the case that the offender is the main reason for the plan or is the person who poses a risk of harm to the child or young person; in some cases, the offender may be helping to protect the child or young person from risks from other sources. However, in the majority of cases we inspected

(90%), the offender posed a risk of harm to the identified child or young person and, in a third of those cases, also posed a risk of harm to other children and young people. We found a small number of cases where the offender was considered to be a protective factor.

- 2.18. In the cases where an offender had a connection to a child or young person subject to a child protection plan, we found that investigations into the nature of the relationship had been made in most cases and checks with children's social care services had been carried out in a high proportion. Police checks had not always been carried out, however, nor was notification of probation involvement always sent. Where there was a risk of harm to children and young people other than those identified, there were a number of instances where appropriate action had not been taken.

Assessment

- 2.19. Offender managers carry out two assessments, one of the offender's needs and the contributing factors to their offending behaviour, and the other of the risk of harm that they pose to others. The overall quality of assessments in cases linked to child protection plans was insufficient. Particularly disappointing was the lack of information sharing and joint working at this stage. In too many cases, separate assessments by the two main agencies involved, children's social care services and probation, were carried out in isolation. We found that:

- 46% of assessments of offending related needs did not take into account information from children's social care services (in Avon & Somerset it was considerably better)
- 62% of assessments of the risk of harm posed by the offender were not shared with children's social care services.

In our judgement this left significant gaps in the assessments of both agencies.

- 2.20. Offender managers did not always utilise the OASys (Offender Assessment System) tool effectively to help them to record and/or analyse complex family structures or relationships, although in Thames Valley we found an example of good practice:

Good practice example: extract from assessment (part of OASys relationships section)

'Mr Garside's current partner is DF. The couple do not live together.

Mr Garside and his ex-partner KB have two children together aged three and one year old. These children are currently looked after by the local authority and the plan is for them to be adopted.

Mr Garside has the care of his four older children from his previous relationship with ex-partner WT. These children range in age from twelve to six years old. The children are all subject to a child protection plan under the category of Neglect (since 2010) and Mr Garside is working with the local authority and the Edge of Care team to try to address the concerns regarding their welfare. This is a significant stress for Mr Garside who loves his children but struggles to meet their needs. Social services involvement was triggered by several domestic incidents between Mr Garside and his previous partners, concerns regarding his health, the children's welfare and the family associates and lifestyle. Mr Garside has completed a Triple Parenting course but there are on-going concerns regards the children's welfare and Mr Garside's ability to meet their needs.

Mr Garside is known to the domestic abuse unit in relation to incidents dating from February 2013 back to 2003. These include conflicts with his brothers, abusive incidents towards DF, KB and WT. For more details see risk of harm assessment'. **(Thames Valley Probation Trust)**

- 2.21. In just under half of all the cases we inspected there was no accurate assessment of the risk of harm posed to identified children and young people. This was particularly concerning given that, in the majority of child protection cases we inspected, it was the offender who was the reason for the child protection plan.
- 2.22. The assessment of the risk of harm posed to children or young people who were connected to a perpetrator of domestic abuse was often muddled. Offender managers did seem to understand that this could cause harm, but did not seem able to work out what the actual risk of harm was in a specific case. It was often vaguely referred to as 'psychological harm'. It was evident that offender managers were not always sure what, if any, risk of harm the offender posed. This was true even in cases where they had categorised the level as medium risk of harm.
- 2.23. Again, offender managers completed the OASys but did not use the assessment tool effectively to help them to work out what the risk of harm actually was. Some assessments were therefore poor and did not adequately describe what danger the offender might pose to the child or young person or how the child or young person might be harmed by contact with them. Some assessments contained contradictory information as the example below illustrates:

Practice example: risk assessment

It was documented within the body of the offender assessment that Mr Querel's son was known to social care because of concerns about him being in the care of his drug-using father and witnessing his violence. Mr Querel was having contact with his son. In the risk assessment section, however the offender manager had answered 'no' to the questions 'Are there any concerns in relation to children?' and 'The offender presents a risk to identifiable children?'

- 2.24. In a small number of cases where children or young people were on child protection plans, we found that offender managers had not completed a risk assessment at all citing the reason as "*child/ren on child protection plan.*"
- 2.25. Where the offence was against children or young people, assessments of the risk of harm posed by the offender were clearer.

Planning to protect children and young people

- 2.26. The fragmented working that we found in assessment unfortunately carried through to the planning. Child protection plans (children's social care services) and risk management plans (Probation Trusts) were not often integrated or aligned. In most cases the child protection plan was not on the probation file, nor had the offender manager had sight of it or knew what was in it. We did not find copies of Probation Trust risk management plans on **any** of the children's social care services files seen. This meant that vital information on safeguarding children and young people was not available.
- 2.27. We found no evidence of any expectation by children's social care staff that probation risk assessments or management plans contributed to child protection planning. Probation assessments and/or plans were not requested or used by social workers. Further, there was no indication that social workers understood the meaning of the risk of harm categorisation used by probation or had considered the way in which they could share tasks to improve outcomes in child protection plans. Unsurprisingly therefore, there was no evidence of a jointly designed single risk assessment, planning and management approach. In the minutes of case conferences, we saw little evidence that chairs had taken any steps to secure the insights, assessments and/or plans from Probation Trusts. Nor did we see any attempts to promote integrated joint work.

- 2.28. Too often there was no role or actions for the offender manager identified in the child protection plan, even where the offender was the reason for the plan. When the agencies came together it seemed that they offered or accepted roles and tasks that fell within their single agency remits rather than considering what was needed to protect the child or young person and then deciding who was best placed to deliver the task or role.

Practice example: lack of joint planning

Mr Abbot had a history of drug abuse and violence against partners and was under probation supervision. He was living alone with his children who were subject to child protection plans. Despite this, there was no attendance by the offender manager at either child protection conferences or core group meetings. It was unclear from the records of both agencies why this had happened.

The child protection plan contained no actions for probation to undertake and there was no evidence that children's social care had seen or taken into account probation risk assessment or plans or had asked for information about his supervision.

- 2.29. In domestic violence cases, the planning to specifically protect children or young people (as opposed to the direct victim) from the harm caused by living with and/or witnessing domestic violence was ineffective and reflected the confused assessments.

Action to protect children and young people

- 2.30. All agencies have responsibilities for protecting children and young people under *Working together to safeguard children 2013*. Probation Trusts have their own responsibilities, assessment, planning and working to help change offending behaviour, as well as the joint work with other agencies to protect any associated children and young people. Whilst some probation staff had grasped this and were sharing information and carrying out joint work alongside their individual offending behaviour work, a number of offender managers, and some more senior staff, struggled to combine the idea of both and talked about the protection of children and young people as not being "core business". Whilst they were able to see their role in 'public' protection, they tended to view work to protect children and young people as something different to be carried out by children's social care services.
- 2.31. The requirements of criminal court orders are intended to deal with offending behaviour and rarely take into account the need to protect children and young people. We saw a number of community orders with just a requirement for unpaid work where the offender was assessed as posing a risk of harm to children or young people or was connected with children or young people subject to child protection plans. In these cases, the response by most Trusts was to allocate a probation officer to carry out a full assessment. However, we did not see any subsequent work to become involved in child protection where it was relevant. It was evident that offender managers felt constrained by the type of order imposed. They did not feel that they could be fully involved unless the offender breached, at which point a recommendation for a supervision requirement was often made. We found no evidence that any of the Trusts had considered how this problem could be dealt with on a strategic level.
- 2.32. Home visits were not used effectively as a routine way to help protect children and young people; we found only just over a third of cases where visits were carried out regularly and used purposefully. It was of note that this was sometimes in direct contravention to the written policy of the Trust which was to encourage such visits. West Yorkshire was the exception, where home visits had been carried out in all relevant cases. Few offender managers thought they had a role in monitoring the safety of children and young people by home visiting.

- 2.33. In some cases it was apparent that the offender manager did not really know what their role was in the protection of a child or young person. This was particularly the case where the offence itself was not connected to child protection or domestic violence. In these cases we saw offender managers attending core group meetings but offering little added value. Disappointingly, social workers and chairs of conferences did not request or seem to require more. Offender managers also struggled to find a role for themselves in the work to help protect children and young people from the emotional impact of domestic violence, and again children's social care services did not help to explore this.
- 2.34. More positively, we saw some examples of offender managers who clearly had considered what their role was. In Calderdale, we found an offender manager who, when the offender's relationship with children's social care services became difficult, increased her input and made a full contribution to the protection of the child as follows:

Good practice example: probation contribution to child protection work

Mr Spratt was under supervision having been sentenced for making/having indecent images of children. When the case was transferred in to Calderdale, he was required to live separately to his wife and son (who was the subject of a child protection plan).

However he returned home and, when questioned by his offender manager, he lied and said that children's social care services had said he could. The offender manager promptly followed it up and he was made to leave again. The offender manager attended all core groups and reviews and the role of probation was clearly identified in the child protection plan. When the relationship between children's social care services and the family became strained the offender manager temporarily assumed the role of broker between them to help to ensure the child protection work was not affected. **(West Yorkshire Probation Trust)**

- 2.35. Overall, however, we judged that the risk of harm posed by the offender to a child or young person had not been managed effectively by Probation Trusts in 15 out of 39 cases where a child protection plan was in place.
- 2.36. The quality of the Probation Trusts contribution to multi-agency meetings varied. Where we saw written reports, they were largely of good quality, contained appropriate information and were focused on child protection (16 out of 22 reports). The quality of other contributions to core groups and multi-agency meetings was mixed. In over half of the cases, we judged that it had been effective, either through proactive verbal contribution at meetings and/or provision of appropriate information.

Good practice example: verbal contribution to review meeting (extract from minutes)

"The probation officer said Ms Verona is subject to a two year Supervision Order and a suspended sentence. There was sustained denial but this was due to her fear of going to prison and advice given by her legal representative. Since admitting the offence they have discussed why it happened and alternative ways of appropriate discipline.

They have explored anger management and carried out work regarding the impact on the victim and on other family members. Ms Verona now has great insight into how it has impacted on every family member.

She has engaged well and she has not missed one appointment, even when she was ill and she has worked hard. She is able to put into practice what she has learnt on the parenting course and there are no major concerns. Initially appointments were weekly but they are now fortnightly and will be monthly from now on. As she is pregnant this will include home visits.

The chair asked Ms Verona how she thought probation was going and she said it was good and it helps her a lot and helps her understand different things about what happened and how to control it, how to stop it happening again in the future." **(Nottinghamshire Probation Trust)**

- 2.37. The previous example shows how integral an offender manager can be to the work of protecting children and young people.
- 2.38. We found that prescribed actions from multi-agency child protection meetings had been carried out by probation staff in over three-quarters of the cases. In two-thirds of cases, the offender manager had continued to monitor the relationship although there was no direct contact with the identified children or young people.
- 2.39. The contribution of Probation Trusts to formal joint child protection work needs to be enabled, informed and facilitated by the lead agency: children's social care services. To this end, we judged that children's social care services were only proactive in sending out timely invitations to child protection meetings in 21 out of 35 cases. Minutes from child protection meetings were not always of good enough quality, produced promptly or forwarded to relevant people. Where offender managers had not been able to attend meetings, they were not always aware of decisions or actions that had been taken and were sometimes working with offenders without full knowledge of the current situation.
- 2.40. We found slightly more joint work (13 out of 33 cases) to protect children and young people than joint planning but still not enough. We saw some cases of good joint work, however, too often it was not clear that each agency knew what the other was doing or what each was responsible for.
- 2.41. Overall, we found that children's social care services had actively promoted joint work with Probation Trusts in only 8 out of 28 relevant cases.

Practice example: lack of joint work

Mr Peterson had previous convictions for domestic violence and was under probation supervision. He left his partner and children (who were subject to child protection plans) and moved in with another woman with children in a different town. Children's social care services convened a meeting of the local domestic violence panel in his new area but did not invite the offender manager who was supervising Mr Peterson.

Information sharing between Probation Trusts and other agencies

- 2.42. Most Serious Case Reviews (Child Practice Review in Wales) where a child or young person has died or has been seriously harmed, find that there has been some failure by agencies to share significant information. Prompt and full information sharing is clearly essential to the effective protection of children and young people. In over half of the cases where child protection plans were in place we found that information had not been shared fully or promptly across agencies (the proportion shared was better in Thames Valley). Even more concerning, in over half of cases, where there had been changes in the level of risk of harm posed, this had not been communicated to children's social care services or appropriate action taken.
- 2.43. The structure and working arrangements within the individual agencies varied enormously and this did not always facilitate good information sharing. There was no doubt that the challenges for some areas are enormous. Generally, offender managers were more confident in communication with police than with children's social care services although there were exceptions.

Good practice example: information sharing by police

In North Wales we found the police operating a streamlined system for swiftly alerting other agencies to incidents in the home where children and young people had been present. Neighbourhood officers were required to complete details of incidents before going off shift, enabling tasking, sharing of information and appropriate referrals to be carried out promptly. **(Wales Probation Trust)**

- 2.44. Offender managers in some Probation Trusts told us that the relationships with children's social care services were good and, where that was the case, we found it was reflected in the sharing of information and referrals. In others, we were told that they found children's social care services, at best, difficult to access and, at worst, unhelpful and a barrier. We were often told that it depended on the particular social worker.
- 2.45. We saw little evidence that any agencies had worked together to produce robust, aligned information sharing processes; rather each agency had developed their own and expected the other agencies to accommodate them. This often left gaps at various stages, for instance responses (or lack of them) to referrals missed, invitations to core groups or conferences not received in time, significant information affecting the safety of a child or young person not shared.

Practice example: information sharing

Sonny, a five year old boy was on a child protection plan. His mother had been convicted of cruelty to him and was under the supervision of the Probation Trust. Minutes from the ICPC referred to the pending court case but children's social care services did not contact probation to request information.

There was no subsequent contact by children's social care services with probation and no invitations to core groups or review conferences; the offender manager made no contact with children's social care services either. The mother had been the subject of domestic violence herself and was misusing alcohol. Ultimately, the offender manager learnt directly from her that a decision to remove the children had been made previously and that her violent partner had returned to the home thereby increasing the risk to her. This had not been communicated by children's social care services.

Referrals

- 2.46. We also examined the referrals that Probation Trusts had made to children's social care services when they had a concern about children or young people which had arisen during the course of contact with an offender. All Trusts struggled to collate information on referrals to a greater or lesser degree. More than one Trust had to approach their local children's social care services to obtain the names of the referrals they had made. It was not unusual for the list of referrals we were given to include cases where no referrals had actually been made. In one Trust we were unable to look at any referrals because the list given to us was entirely wrong.
- 2.47. The process for referrals was not consistently applied – some were made by telephone, some by email and some using a referral form. Offender managers were not always sure what the exact procedure was.
- 2.48. Of the referrals which we were able to inspect, most were timely and three-quarters contained full details of the child or young person and described the nature and level of the risk of harm. That left a quarter which, variously, did not contain full detail, did not describe the nature of the risk and/or did not specify what response was required from children's social care services. In some cases, it seemed that offender managers had not considered what response they wanted, or what they thought children's social care services could do. Rather, they had made a referral to follow a procedure.
- 2.49. The response from children's social care services was not always timely. Too often this was not followed up by the offender manager and in too many cases, once the referral had been made, no further action was taken by the offender manager irrespective of the response, or lack of it, from children's social care services. In West Yorkshire however, all referrals made were timely, as was the response from children's social care services, which was also considered satisfactory in all cases.
- 2.50. There was often no formal process for monitoring the response to referrals; it relied on the offender manager remembering to do so. However, in one Trust which did have a process, it had still not

resulted in referrals being followed up where necessary. Additionally, the recording of referrals on case files was not always evident, or was often hidden in case notes and did not drive any follow up.

Practice example: lack of content in referrals

In one trust, we found the following referral regarding a man with a history of domestic violence and his new partner who had a baby: *"My main concern regarding the welfare of the child is that firstly Mr Stevenson is likely to be going into custody and I know little about the support that his partner has as I have not met her, and secondly he has a history of violence"*.

2.51. We saw an example of how this could potentially leave a child or young person in danger:

Practice example: following up referrals

Following a serious incident where Mr Tomlinson was alleged to have thrown a hammer at a young child and pretended to burn him with alcohol and a cigarette lighter, the offender manager immediately alerted children's social care services by telephone message but received no response and did not escalate the matter. There was no evidence that this message was ever received on children's social care services case file. The offender manager did not follow up this telephone referral to find out what action had been taken until four months later.

Management oversight

2.52. Given the inability of Trusts to collate information on referrals, it is perhaps not surprising that we found little or no managerial oversight. This meant that we found instances where the offender manager had not recognised the need to refer and it had not been picked up by a manager, for example:

Practice example: lack of recognition of the need for child protection

Mr Olivier had a long and established history of domestic abuse against a previous partner. He entered into a new, arranged marriage with a woman who was new to the country and spoke very little English; she became pregnant. Despite this, a referral to children's social care services was not made.

2.53. Management oversight of this area of work is particularly important given the age and vulnerability of the potential victims. We found little evidence in any of the Trusts of active, routine and effective management oversight of practice. The majority of offender managers to whom we spoke (20 out of 26) told us that their work to protect children and young people was discussed in supervision. It was a standing item on the agenda for only 12 out of 26 practitioners, however; the rest had to bring cases to the attention of managers.

2.54. Probation Trust information systems did not aid either the quality of operational case management or the management oversight of cases. They were often unclear at best and at worst, absent. Additionally, we found some cases 'flagged' as child protections which were not. In Thames Valley some managers were using a 'risk register' to identify cases.

2.55. These shortcomings in management oversight and systems are a matter of serious concern because it means that Probation Trusts often have no way of knowing if potential child protection concerns

have been acted upon or any way of collating information to see what needs to improve and what is done well.

Conclusion

- 2.56. The quality of the contribution to child protection work by Probation Trusts was variable, both across and within the inspected organisations. We saw some good interventions where offender managers clearly understood the risk of harm issues, and worked well with other agencies to manage them and to protect children and young people. We saw other cases where offender managers clearly did not understand the nature of the risk, had not worked out what their role was and either did not work with other agencies or were very passive. In some places, work to protect children was not seen as 'core business'. As a result, we could not be confident that children and young people were as adequately protected as they might be, in all the cases we inspected.
- 2.57. In some cases the other agencies, primarily children's social care services, had enabled, facilitated and encouraged the contribution of offender managers thereby improving the protection of children and young people. However, in too many they had not.

**Work by Youth
Offending Teams to
protect children and
young people**

3

3. Work by Youth Offending Teams to protect children and young people

Summary

This chapter describes the work of YOTs with children and young people and their parents/carers and the contribution of the YOT to joint work to protect them. This work includes identification, assessment, planning and action to protect as well as information sharing and management oversight. It refers specifically to the emerging work to address child sexual exploitation. It also evaluates how well children's social care services facilitate joint work.

Key findings

- Assessment and planning arrangements were in place to help to protect children and young people where necessary, however it was not always of sufficient quality. Parents/carers were not always appropriately involved and home visits were not always undertaken.
- The assessment of a child or young person's vulnerability and the planning to reduce it was not always of sufficient quality.
- There was little joint assessment and planning and children's social care services did not always facilitate good information sharing or encourage joint work.
- There was some excellent and imaginative direct work with children and young people and their parents/carers, and some good partnership work.
- Management oversight systems were in place but are not always effective.
- Work to combat child sexual exploitation was being developed.

Identification of children and young people who are involved with children's social care services

- 3.1. YOT staff can come into initial contact with children and young people at a variety of stages in the criminal justice process. Some YOT staff acting as Appropriate Adults for children and young people either in police custody or involved with diversion schemes will meet the child or young person before they are charged with any offence. Alternatively the first contact may be at the pre-sentence stage for report writing or may not take place until after sentence. In any of these circumstances, little may be known by the YOT about the child or young person and so early enquiries should be made of children's social care services to establish if they are known and, if so, the nature of children's social care services involvement.
- 3.2. YOT work with children and young people is primarily about helping them change their offending behaviour and protecting victims or potential victims from any risk of harm that they may pose. However, YOTs also have a vital role in assessing the child or young person's vulnerability and working to help protect them where necessary in collaboration with other agencies who are involved.
- 3.3. To enable us to ascertain whether the YOT was making sufficient initial enquiries with children's social care services, we inspected 83 randomly selected cases opened in the three months prior to the inspection fieldwork. We were looking to see:
 - if checks were made with children's social care services

- that notification of YOT involvement was communicated to children’s social care services where they were involved
 - whether the necessary referrals were made to children’s social care services where appropriate
 - that all necessary action was taken to protect children and young people.
- 3.4. All the YOTs had procedures in place to check whether children and young people were known to children’s social care services. These were often started by administrative staff and followed up by case managers where necessary. Most YOTs had direct access to the children’s social care services database, some on a read only basis, and some with inputting capability. This information was recorded on YOT case record systems.
- 3.5. In the randomly selected cases, we found that timely checks were made with children’s social care services in all but two instances and there was timely notification of YOT involvement in all but one. Furthermore, in all but one case, where there were child protection issues, they had been recognised.

Children and young people already on child protection plans

- 3.6. In the sample of 36 cases where there was a child protection plan in place, we found that enquiries had been made in all of them and where children’s social care services were found to be involved, timely notification of YOT involvement was sent in all but three. The notification was not always clearly recorded on children’s social care services records however. Checks with police and probation were less consistent. In relevant cases, they had been carried out with police in 16 out of 24 and with Probation Trusts in 4 out of 11.

Assessment

- 3.7. Case managers carry out three assessments; one of the child or young person’s needs and what is contributing to their offending behaviour, one of their vulnerability and safeguarding needs, and one of the risk of harm that they pose to others. The tool used to carry out the assessment of the offending related needs of the child or young person is known as Asset. This is supplemented by a vulnerability screening which draws together factors identified in the Asset which may make the child or young person vulnerable. This is the main assessment of vulnerability and safeguarding need carried out by the YOT.
- 3.8. Across all the cases that we inspected, child protection issues had largely been recognised and appropriate action taken. In a small number of cases however, (5 out of 26) risks to **other** children or young people had not been recognised and as a result appropriate action to protect them had not been taken by the YOT.
- 3.9. The quality of assessment of the safety of the child or young person varied considerably both across and within YOTs. In Bromley we found that all but one of 20 cases had been sufficiently well assessed. Across all the YOTs inspected, we found some very good assessments, although a small number were particularly poor. There were various reasons why assessments were judged insufficient:
- information from children’s social care services did not always feature in the assessments we saw
 - contact with parents/carers and home visits varied widely ranging from all cases in some YOTs to less than half of cases in others
 - vulnerability screenings failed to draw all the factors together, they did not always consider the full range of problems, they lacked analysis, and they did not come to a clear conclusion about what the risk to the child or young person actually was.

- 3.10. Assessments were not routinely and consistently shared with children's social care services in any of the YOTs we visited, although practice did vary and the proportion was higher in some than others. We did not find any copies of YOT assessments on children's social care services files. With some exceptions, YOT assessments did not generally contribute to assessments by children's social care services. There was little evidence of any joint assessments made by YOTs and other agencies with the exception of Reading where the use of the model *Signs of Safety* appeared to be contributing to more joined-up work.

Good practice example: joint working model: *Signs of Safety*

The *Signs of Safety* model is intended to help practitioners with safety planning in child protection cases. Its aim is to enable practitioners across different disciplines to work collaboratively and in partnership with families and children. The tools are designed to help conduct risk assessments and produce action plans to reduce risk and danger by identifying areas that need to change while focusing on strengths, resources and networks that the family has. The use of common language helps to avoid assumptions and misunderstandings and ensures that all agencies are clear about the risks posed and the work that needs to be carried out.

Planning to protect children and young people

- 3.11. In the majority of cases, parents/carers were not involved in the YOT planning or included in YOT supervision plans; the plans were not generally shared with them.
- 3.12. Most vulnerability management plans (VMPs), the vehicle YOTs use to plan safeguarding and child protection work, that we assessed did not clearly identify actions to be taken, nor were the actions of other agencies clearly described. Many were descriptive rather than task or outcome focused and we found too much contextual information which often obscured the tasks or actions to be taken.
- 3.13. In Reading we found a plan produced by a young person and her case manager to help the young person stop self-harming:

s Safety Plan

What I need to do to reduce the risk of me acting on suicidal thoughts?

- Throw away blades/tablets/glass
- Mum to lock away tablets/blades/glass
- To have no tablets/blades/glass in the house (keep them at' ___ s)

What warning signs or triggers are there that make me feel more out of control?

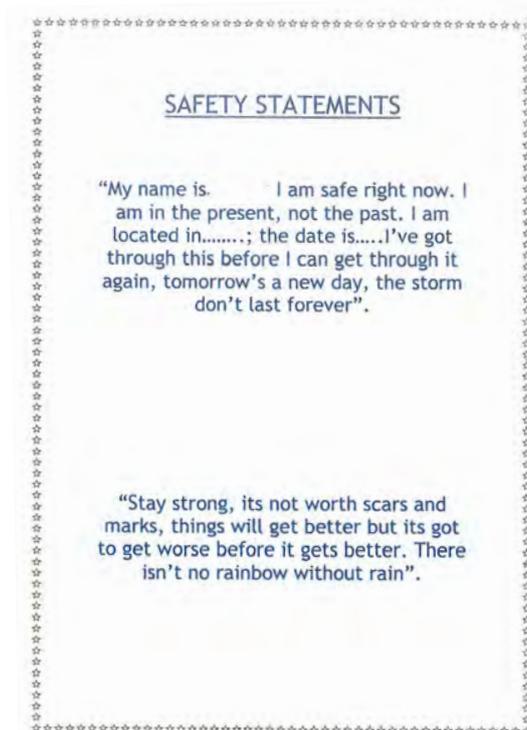
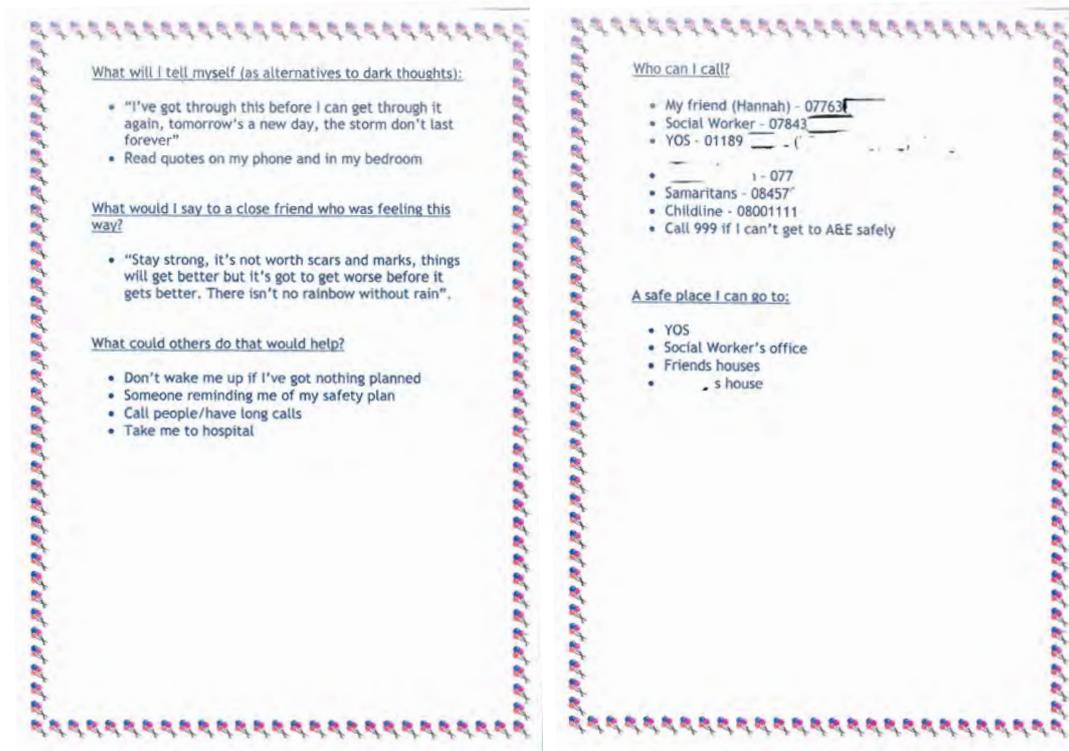
- Being grounded - don't get grounded
- When my Mum moans about anything - ignore her
- Silly things - tell myself its silly
- When I argue with family/friends - Walk away
- Waiting for things/people - Leave them or distract myself
- Having to wake up early - go to bed early
- Being stuck at home - get out of the house more/go to meet friends

What have I done in the past that helped? What ways of coping do I have?

- Elastic band
- Gone on a walk

What will I do to help calm and soothe myself in the future:

- Eat chocolate
- Hot bath
- Writing down my thoughts in a diary
- Do some art/drawing
- Listen to music
- Do something constructive to get myself out of the situation
- Go to sleep
- Call - friend/YOS/Social Worker/999
- Long walk
- Breathe in and out concentrating on your breathing (see exercise)
- Hold ice cube in your hand and squeeze it really hard
- Instead of cutting use red pen or nail polish
- Digging your finger nails without breaking your skin/bite yourself
- Elastic bands
- Watching funny videos
- Screaming into a pillow
- Throw soft things at a wall
- Pillow stick pins in it
- Cry
- Get out more to take my mind off things
- Get a reasonable amount of sleep
- Clench and release my fists
- Saying kind things to myself
- Remind myself that I am safe (see exercise)
- Calling a friend and chatting
- Calling Social Worker or somebody at YOS



- 3.14. With the exception of Reading, we did not always find child protection plans on YOT files or evidence that they had been taken into account by YOT staff. Conversely, there were no VMPs on any of the children's social care services files and little evidence that they had been seen or taken into account by that agency in their own planning. Where we saw the *Signs of Safety* model being used, the planning was better aligned.
- 3.15. With some notable exceptions, we saw no evidence of any **joint** planning involving the YOTs. When the agencies came together it seemed that they offered or accepted roles and tasks that fell within their single agency remits rather than considering what was needed to protect the child and young person, and then deciding who was best placed to deliver the task or role.

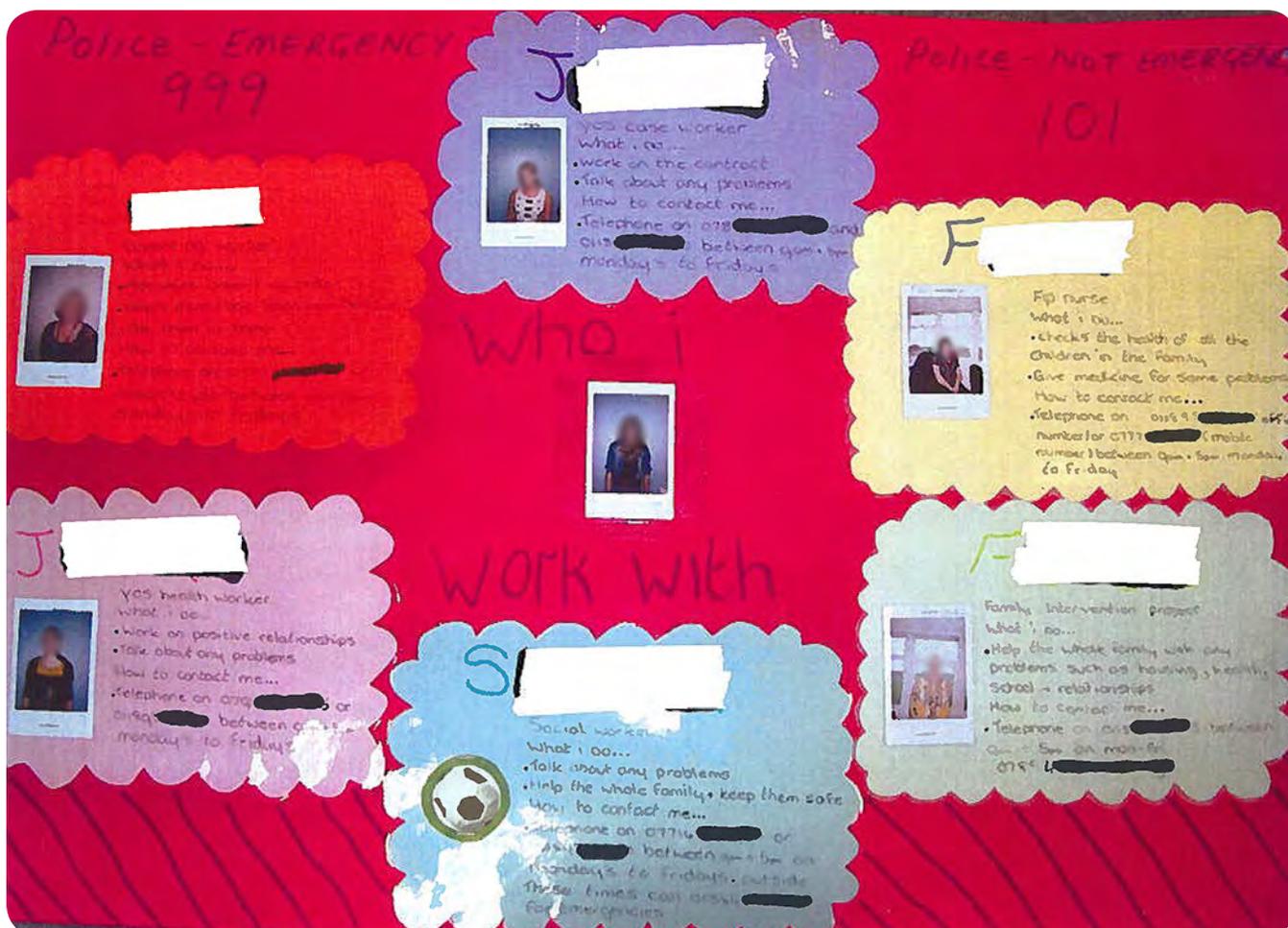
3.16. In some places there was little visible evidence on children's social care services files that social workers understood the role of YOT workers in helping to protect children and young people or the way in which they could share tasks to improve outcomes in child protection plans.

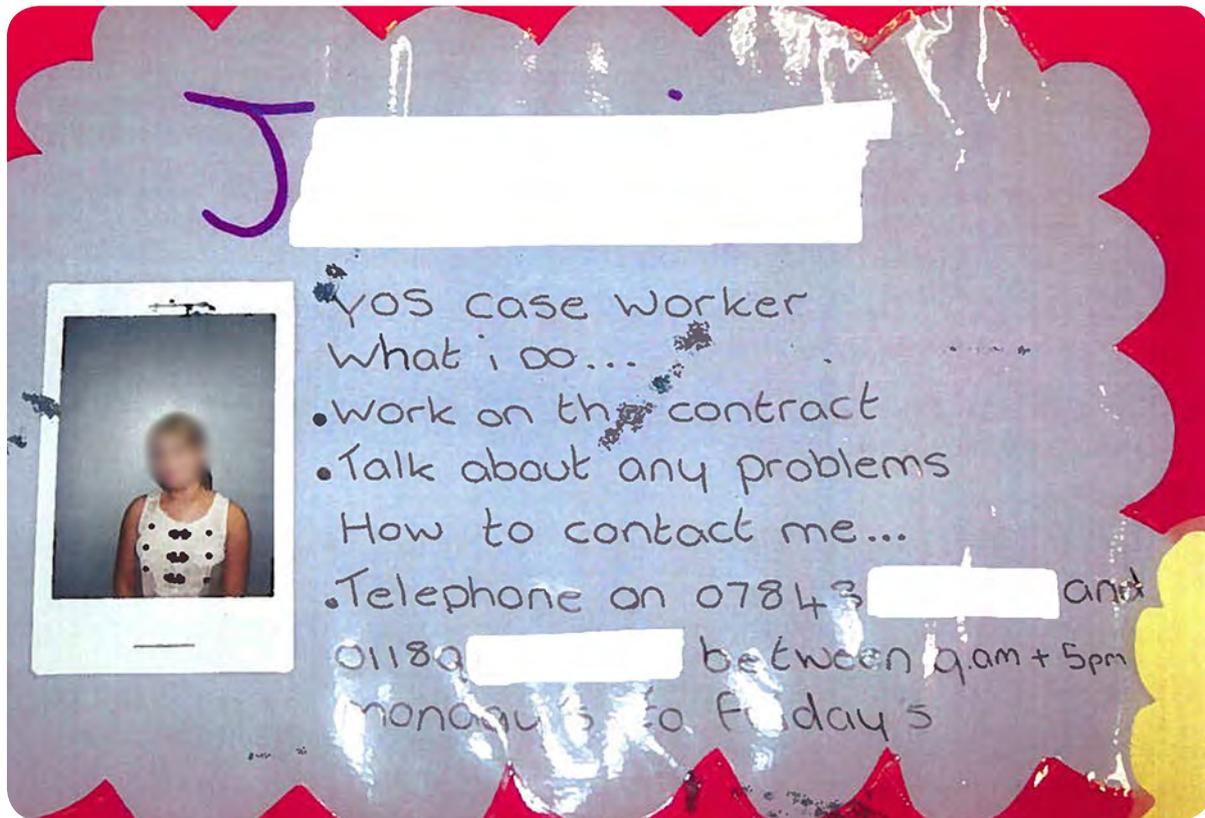
Action to protect children and young people

3.17. In multi-agency work, YOT workers were often the most closely and directly involved with children and young people. We found some excellent, imaginative and protective face-to-face work by case managers and other YOT workers with both children and young people and their parents/carers.

Good practice example: engagement with a young person

In Reading, we found an imaginative response by a YOT worker to a young person who had complained that she could not remember all the people she was involved with. Her case manager had used Polaroid photos and coloured card to help her create a visual record of all her workers, including what their role was and their contact details. **(Reading YOT)**





- 3.18. Practice did vary, however, and in some YOTs we could not see any specific work to protect children and young people apart from attendance at meetings. In one case, for example, there had been no home visits undertaken throughout the order. Generally, however, home visiting was undertaken as part of YOT work and we saw some joint visiting with children's social care services. We felt that the purpose of home visits needed to be more clearly defined to emphasise how they could be used to monitor child protection issues, however, it was good to see it happening.
- 3.19. In some YOTs action was not taken when a new risk presented itself or an existing risk escalated. Changes in the level of safeguarding need were not always recognised and responded to, and a change in circumstances did not always prompt a review of the assessment and/or plan. Where the implication of changes were recognised, the information was not always shared with other agencies. We also saw a number of reviews that were copied and redated; a completely pointless exercise.
- 3.20. Not all children's social care services issued timely invitations to YOTs or involved them in decision making. Our inspection data showed a correlation between timely invitations to meetings and the amount of joint work carried out and this was apparent in Reading and Nottingham City where invitations were generally timely.
- 3.21. With some exceptions, there was largely good attendance and active contribution by case managers and other YOT staff at multi-agency meetings. Minutes showed that some YOT workers were not vocal enough however and, in discussion, it was evident that not all were entirely clear about their role and responsibilities in those arenas. Where this was the case, it was not clear what steps chairs were taking to secure the insights and engagement of YOT workers. With the exception of Reading, minutes from multi-agency meetings did not always clearly describe the actions of the YOT. Where they did however, YOTs were carrying them out.
- 3.22. Reports to multi-agency meetings generally contained all relevant information and were sufficiently focused on child protection. There were some which did not and we found no quality assurance processes around these reports. In Reading we found that reports written in the language of the *Signs of Safety* model helped to break down the language barriers between agencies, contributed to clear actions for the YOT within child protection plans and promoted more joined-up working.

3.23. Where there was good joint work to protect children and young people we saw trust, respect and a desire to work collaboratively between social workers and YOT staff resulting in prompt information sharing, thoughtful allocation of roles and tasks and more coordinated working. Where this was not the case we found:

- agencies carrying out their own processes without proper consideration of the purpose; the protection of the child or young person
- a lack of understanding of each agency's role
- agencies working in isolation
- gaps in knowledge about events or changes in circumstances
- missed meetings
- poor quality or absence of contribution to multi-agency meetings
- actions not followed up
- drift and lack of progress
- children and young people working with a number of people who asked them the same things.

Good practice example: joint work

Nathan's father was living away from home because of offences in relation to possession of indecent images of children. His mother was disabled and had attachment issues with Nathan, which led to a strained relationship. He was not fed properly, was undernourished and he wanted to live away from the family home. The YOT case manager made immediate contact with children's social care services when the referral order was made and put in a suitable report to the next child protection review meeting saying:

"My concern from an offending perspective is that Nathan is increasing the risk of becoming involved in further criminal activities. Given the information I have collated, I am extremely concerned about his well being, both physical and emotional. I recommend that he is accommodated and there is an alternative living arrangement for him".

The agencies worked together to develop a robust plan for him which involved living with foster parents, helping him engage with an outside agency to discuss sexual risks relating to the lifestyle he had been leading. The YOT arranged a referral to a gym, which he was keen to attend and, as he was a cannabis user, put in place sessions re substance misuse.

Nathan was moved to fostering accommodation. His health improved, and he had not come to the attention of the YOT again 14 months after the end of his order. **(Calderdale YOT)**

3.24. The work to protect children and young people is particularly complex where they also pose a risk of harm to other children and young people. We found some confusion in both YOTs and children's social care services in these cases. It was managed well by YOTs in 8 out of 15 relevant cases.

Practice example: where a child on a child protection plan also posed a risk of harm to others

14 year old Jack already had a previous offence of assault on his sister when he went to live with his father who had a history of committing domestic violence. Jack's half-siblings, already living there, were on a child protection plan and he was placed on a plan too. Jack's behaviour was not considered or taken into account in the protection of the other children. When he resumed living with his mother and siblings, the child protection plan pertaining to him remained in place, but again, there was no consideration of the risk he posed to his siblings. There were numerous incidents of violence towards them by him. He was reported to have been carrying a baseball bat and to have another weapon, but this was not explored by either agency. Jack also had a 14 year old girlfriend but there had been no consideration of whether she was at risk of harm from him.

Child Sexual Exploitation

- 3.25. We were surprised by the recurrence of indicators of child sexual exploitation in many of the cases we inspected. We saw some suspicion or identification of factors in nearly all of the cases of girls and young women and in a small number of boys and young men.
- 3.26. Most areas had a multi-agency response in some degree of development. Multi-agency panels had been set up in some areas to identify potential victims and in some cases we saw effective partnership work to protect the victim, disrupt what was happening, and deter the offender.

Good practice example: work with child sexual exploitation

In Calderdale the LSCB had set up a multi-agency operational group to tackle child sexual exploitation and the YOT was actively engaged in the group. There was effective police led multi-agency operational practice around vulnerable children and young people. The use of a specific risk management tool and monthly monitoring meetings was well established and was visible in the cases we saw.

(Calderdale YOT)

- 3.27. This is especially complex work because often the victim does not see themselves as a victim and can be difficult to work with. We were disappointed in some places to hear that a child or young person "wouldn't engage" as, in our judgement, that is the job of the practitioner.

Practice example: failing to engage a young person

In August 2012, 14 year old Rhianna was placed on a child protection plan due to concerns about sexual exploitation. It was thought that she was being targeted by a known gang member and she had been found to have gonorrhoea. Her father had died in 2010. Her mother had alcohol problems and their relationship was strained. She was failing to attend school.

Initially the family was to work with the NSPCC. Rhianna was hostile to her social worker and absented herself from all statutory visits. The police and children's social care services closed their cases in April 2013.

It was difficult to see what useful actions had been taken or that there had been any changes in her life as a result of the involvement of children's social care services, the police and the YOT. When the case was closed she was still not attending school and it seemed to be the absence of any negative factors rather than positive progress that prompted the closure.

- 3.28. In some places however we saw YOT practitioners and partners working together and making persistent efforts to establish trust and carry out protective work with highly vulnerable children and young people. In Reading and Bromley we found the use by police of child abduction warning notices⁹ as a means of protecting children and young people from adults assessed as posing a risk to them.

⁹ Child abduction warning notices identify the child and confirm that the suspect has no permission to associate with or to contact or communicate with the child and that if the suspect continues to do so, the suspect may be arrested and prosecuted for an offence under section 2 *Child Abduction Act 1984* or section 49 *Children and Young Persons Act 1989* or for any other criminal offence committed in relation to that child.

Good practice example: multi-agency work on child sexual exploitation

Sheila was already the subject of a child protection plan for neglect when she received a referral order for making nuisance calls to the police. A parenting order was made at the same time. As work with the family progressed it became apparent that she was at risk of sexual exploitation.

A thoughtful and considered proposal by the YOT to the Referral Panel at the start of the order resulted in an extended order to allow proper assessment through referrals to physical and mental health and substance misuse workers. The parenting worker, who had a previous relationship with the family started work in the interim and formal panel reviews were established on a more frequent basis than usual to avoid drift.

The YOT made considerable attempts to engage Sheila and the parenting worker did a lot of work helping the family to understand what they needed to do to keep Sheila safe and 'control' her. The police responded to calls from her parents when she went missing and returned her home. At the same time, they were attempting to gather intelligence about the men involved and there was good information sharing across all agencies. When the Family Intervention Project began work with the family, it was well integrated with the other agencies. Fortnightly multi-agency strategy meetings were well attended and considered her needs and those of other girls at risk.

When the referral order ended the YOT offered Sheila a weekly opportunity to 'drop in'. **(Reading YOT)**

Information sharing between YOTs and other agencies

- 3.29. With the exception of Reading, where the sharing of information between children's social care services and the YOT (both ways) had taken place in all cases, YOTs had shared information about child protection issues promptly in less than half of the cases.
- 3.30. YOT staff did not always find out from Probation Trusts in appropriate cases, for example where there was some indication that an adult in the household may have convictions. Out of 11 relevant cases, enquiries had been made in only 4.
- 3.31. Information sharing by police child protection units was largely through children's social care services whom they relied upon to pass information on to YOTs. Police systems did not always aid information sharing. The role of police offices within the YOTs inspected varied. In some areas, it was assumed, not always correctly, that the YOT police officers would obtain police information. Whilst police officers were seeking and sharing intelligence in some YOTs, in others their role involved delivering cautions and/or working with victims. They did not always have access to the relevant police database. Case managers themselves were not always aware of the need to check police intelligence or its use.
- 3.32. In Flintshire, the Youth Justice Service (YJS) managed children and young people identified as high vulnerability through a multi-agency meeting which they chaired; this process clearly facilitated the sharing of information. We also saw good liaison with the Multi-Agency Risk Assessment Conference (MARAC) by the YJS where there were children or young people involved.

Referrals

- 3.33. The majority of referrals we inspected contained full details of the child or young person and the nature of the child protection concern. In two YOTs (Bromley and Bath & North East Somerset) this was the case in all the referrals. In Bromley, we saw evidence of YOT workers seeking intelligence from police about gang affiliation and recording it on the referrals. The information from the police was both useful and comprehensive.

- 3.34. Referrals were not recorded consistently either across or within YOTs and case managers were not always following the agency's procedures or using formal channels. Sometimes a telephone call or email was used and this made it more difficult to ensure a response was received.

Good practice example: escalation of a referral by the YOT

15 year old Roberta was referred by the YOT to children's social care services twice in consecutive months. Initially the YOT felt she met the Child in Need threshold and subsequently that she was in need of formal child protection. Roberta had attempted suicide and the YOT believed she was at risk of sexual exploitation. When the response to the second referral was that there would be no action, the YOT escalated the referral by pointing out that children's social care services were not following their own guidance. This prompted a professionals meeting shortly afterwards where Roberta became a Child in Need and a multi-agency response was provided to attempt to protect her from sexual exploitation. **(Flintshire YOT)**

- 3.35. All but one referral that we saw was timely, however the response from children's social care services was not in nearly half; this was not followed up by the YOT in 11 out of 17 cases. In nearly half of the referrals, we judged the response from children's social care services to be unsatisfactory in some way and in most of those there had been no escalation by the YOT. In some cases, it seemed to us that case managers had been too ready to defer to children's social care services in their assessment. In Flintshire we found better practice:
- 3.36. Thresholds for referral to children's social care services were not always fully understood by YOT workers. In Bath & North East Somerset there was a policy that YOT workers could 'call and ask' children's social care services if they were unsure. In some cases, it was not clear what the YOT wanted or expected children's social care services to do.

Practice examples: unclear referrals

17 year old Ada was referred due to the risk of domestic violence from her boyfriend. She was living independently and when she and her boyfriend argued her response was to drink alcohol to excess and self harm/attempt suicide. It was not clear what the case manager wanted or expected a social worker to do.

14 year old Pietro had been threatened via Facebook. It appeared to have been a situation where the young person's own behaviour was also in question. The case worker made a referral when they should have contacted the police.

Management oversight

- 3.37. Children and young people who offend are not always recognised as needing protection and therefore management oversight is particularly important. The quality of management oversight varied in the cases we inspected. In some YOTs, managers were actively involved in case management, whereas in others they were countersigning, without challenge, work we judged to be unsatisfactory.
- 3.38. Managers were involved in various types of panels to reduce the vulnerability of children and young people and, in the ones we judged to be the most useful, there was a reflective discussion often with other practitioners.
- 3.39. Some managers were using performance management information not only to monitor but also to strive for continual improvement (Calderdale YOT had undertaken an audit of vulnerability management plans to help drive improvement) whereas others were using it merely to check that processes had been carried out.

- 3.40. In some YOTs, vulnerability and child protection was high on the agenda within supervision, in others managers were more reactive and it was discussed only when it was raised by case managers. In Bath & North East Somerset they had audited supervision records to check whether safeguarding was being discussed. In Nottingham City the move to more reflective supervision was linked to the quality assurance process and the use of specialist practitioners for coaching where the need was indicated.
- 3.41. Case managers felt that escalation processes were effective when used although, as some case managers were unclear about thresholds, we were unsure that they were always appropriately instigated. The lack of monitoring of referrals made it difficult for managers to have an informed view about the general response of children's social care services.

Conclusion

- 3.42. There were good systems in place in YOTs to identify children and young people who were known to children's social care services and, in general, systems for referral to children's social care services worked. However, although systems were generally effective, not all staff were confident in dealing with this area of work and needed to have a clearer understanding of their role in complex multi-agency child protection work in order to ensure that children and young people were fully protected.
- 3.43. The quality of vulnerability assessment and planning was not consistent. Identified factors were not always recognised as making the child or young person more vulnerable, parents/carers were not being involved and home visits were not always undertaken. In our judgement the assessment of a child or young person's needs and their need for protection cannot be properly made without seeing their home and talking to those with whom they live.
- 3.44. Despite these areas for improvement, YOT staff were working hard and proactively to help to protect children and young people. We saw some excellent and imaginative direct work with children and young people and their parents/carers. We also saw some good partnership and joint work. Overall, in most places, YOTs need to build on and develop existing systems and practice in order to ensure that as much as possible is done to protect children and young people.

Management and leadership

4

4. Management and leadership

Summary

This chapter describes the national and local governance arrangements in relation to the work of protecting children and young people. It evaluates the Probation Trust's and YOT's arrangements and the contribution to, and challenge of, the LSCB.

Key findings

- Both Probation Trusts and YOTs had policies and procedures in place and local guidance on multi-agency responsibilities to enable them to contribute to the protection of children and young people.
- Safeguarding work within Probation Trusts was not always a priority for strategic managers.
- NOMS guidance has not been updated to include *Working Together to Safeguard Children 2013*.
- Effective links between LSCBs and YOT Management Boards were not always in place.
- The impact of Probation Trusts and YOTs on the work of the LSCB was not always evident and the Board did not explore or challenge the contribution.
- Data monitored by LSCBs was focused on children's social care processes rather than outcomes.

Probation

National

- 4.1. The guidance provided to Probation Trusts: *Safeguarding Children – Checklist for Offender Managers* was issued in September 2009 from NOMS. It had therefore not taken into account the 2010 *Working Together* guidance or been updated to take into account the updated *Working Together to Safeguard Children 2013*. In this respect national guidance had fallen behind local guidance and practice.
- 4.2. In 2010 NOMS established a specific post, Senior Policy Developer, with responsibility for working across Government to bring together a NOMS strategy and to ensure that safeguarding was embedded in all new policies. In particular, it was envisaged that the learning from Serious Case Reviews would be disseminated across the organisation. In practice, this had yet to come to fruition. In addition a Probation Instruction¹⁰ relating to access to information on barred status of offenders and changes to the disqualification order regime was issued in February 2014.

Local

- 4.3. All Probation Trusts we visited had a senior manager with strategic responsibility for child protection work, however, in some they were more active than others and child protection was not always seen as a strategic priority. In London there had been some determination to raise the profile. A manager had been appointed to develop the practice across the city. Each probation local delivery unit (LDU) had champions to promote and support practice. In Wales there was a specific work stream under their Excellence in Offender Management initiative.
- 4.4. There were policies and/or procedures in all areas around identification, referral and contribution to the work of children's social care services although not all were up-to-date, not all were familiar

10 Probation Instruction: [02/2014 - Safeguarding of children and vulnerable adults](#) Ministry of Justice, NOMS 2014

to offender managers and not all were followed. We found little guidance on the type of work that offender managers themselves might carry out, or any help in thinking about what their role is in child protection work. Most of the Trusts had some form of quality assurance audits in place and although few had specifically targeted child protection cases, there was evidence that child protection issues had been recognised. Thames Valley had established an audit process following our inspection in 2010 highlighting the need to do so.

- 4.5. All offender managers we interviewed had received some form of basic child protection training, although not all of that was recent and a small number did not feel it had been helpful. In some areas, probation staff were involved in delivering the multi-agency training through the LSCB training sub-group, whilst in others probation services were not even represented on the sub-group. Despite this, less than half of those we interviewed felt fully equipped to carry out child protection work and a quarter said they were not conversant with their agency's procedures. Over a quarter did not understand the children's social care services referral thresholds. In London, it had been recognised that offender managers needed more specific training and the NSPCC had been commissioned to deliver it. In Thames Valley, we were told that staff had received some training in the *Signs of Safety* approach. We saw no evidence of this on case files however. In Wales, this model had been used in part of the Trust for a number of years.
- 4.6. Largely there was attendance at LSCBs by senior and/or operational managers from Probation Trusts and YOTs, although in places it was patchy. It was undoubtedly onerous in the areas where there were a number of LSCBs which did not align with probation LDUs. For example, in Thames Valley there are nine LSCBs and five LDUs; additionally there are LSCB sub-groups.
- 4.7. The links between the MARAC, Multi-Agency Public Protection Arrangements (MAPPA) and children's social care services meetings such as core groups and conferences were often not clear. In some places, we were told that children's social care services did not attend relevant MARAC and/or MAPPA meetings (where there were child protection issues) seemingly mirroring the inconsistent attendance by probation staff at meetings convened by children's social care services. In London, a protocol between MAPPA and the LSCB had been agreed.

Youth Offending Teams

National

- 4.8. The YJB has a strategic objective to help to protect children and young people: *'We will work in partnership across the community and commission the secure estate to promote the safety and welfare of children and young people in the criminal justice system.'*
- 4.9. At the time of the inspection, the YJB was preparing a *Safeguarding Statement* which was intended to set out the position of the organisation in regard to child protection.
- 4.10. In 2013 a new procedure for monitoring the YOT response to serious safeguarding incidents was launched, and a YJB Safeguarding and Public Protection Incident Working Group was established to oversee the process. The group reports to the YJB's Safeguarding Governance Panel, which provides oversight and strategic management to multi-agency safeguarding. At the time of the inspection, it was too early to judge the effectiveness of the new system.
- 4.11. We were unable to find any national guidance aimed at the specific circumstances of children and young people who have offended and their related safeguarding needs.

Local

- 4.12. The governance of YOTs is through a management board whose members are senior officers from the statutory agencies of children's social care services (with representation from education), police, probation and health. Over time, in some places, these boards have become subsumed or merged into a variety of formats under local authority structures. There is generally however a distinct entity.
- 4.13. The original intention when YOTs were established of seconding social workers into YOTs from children's social care services was to ensure that there was safeguarding knowledge and expertise within the organisation. Secondment to YOTs has now become less widespread and there are fewer YOT workers with direct child protection experience. Although most case managers felt fully equipped to carry out child protection work, over a third were less confident. The majority said they were fully conversant with the child protection procedures within their YOT however a quarter said they were only partly aware.
- 4.14. Most case managers had received multi-agency training related to child protection. In some cases, training was very out of date. Managers were not always monitoring this and training records were not always comprehensive. In one YOT we found a worker who had been seconded for two years and not had any child protection training. In Reading, case managers spend a day with various children's social care services teams as part of their induction and new social workers spend some time in the YOT.
- 4.15. Links and lines of communication between YOT Management Boards and the LSCB were not always formal or well established and YOTs were not always directly represented at the LSCB. We were often told that the person representing children's social care services on the LSCB also represented the YOT but we generally found no evidence in minutes of discussion of the specific safeguarding needs of children and young people who have offended.

Good practice example: strategic safeguarding of children and young people who have offended

In Nottingham, a Safeguarding Assurance Forum had been established. Its purpose was to provide an overview of safeguarding risks and issues within the system and evidence effective oversight of Nottingham City Council safeguarding and early help services. The independent chair of the YOT Management Board was an active member and contributor, ensuring that the needs of children and young people who have offended were always taken into account. **(Nottingham City YOT)**

Children's social care services and LSCBs

- 4.16. The introduction of Multi-Agency Safeguarding Hubs (MASH), described by a different name in some areas, was in different stages of development. Generally a MASH co-located a range of agencies which can include police, children's social care services, education, Probation Trusts and health staff to receive initial enquiries about safeguarding and child protection and to share information. MASHs' were structured differently, however, and did not all carry out the same processes. Where a MASH was established, systems and processes were generally better. For example, the MASH in Reading, has led to simpler and swifter referral and assessment processes.
- 4.17. The YOT link with the MASH was generally as a referrer. Calderdale had piloted the secondment of a worker but this had proved wasteful of resources. Of the case managers we interviewed, just over half felt that children's social care services were easily accessible and helpful in aiding their understanding of child protection issues.
- 4.18. LSCB minutes showed limited evidence that probation and YOT representatives were assertive in raising issues or that the LSCB was proactive in engaging or challenging them. In most areas, it was difficult to see any obvious impact made by the contribution of either agency. In one area

where there were clear issues about information sharing by children's social care services with the Probation Trust, we could see no evidence that this had been raised by the probation representative on the board. More widely, we saw no exploration at any of the LSCBs of the far-reaching changes to probation structures which are likely to have a significant impact on joint working through the creation of the National Probation Service and the creation of Community Rehabilitation Companies.

- 4.19. Probation Trusts and YOTs had little involvement in the sub-groups of the LSCB with responsibility for auditing cases on a multi-agency basis. In one area we were told that probation could not take part because children's social care services were unwilling to share their files for legal reasons. We were surprised that the LSCB had accepted this. In more than one area there had been a Serious Further Offence committed upon a child by an offender known to probation but this had not been discussed by the LSCB.
- 4.20. There was little outcome data available to most LSCBs. What data was available was generally focused on children's social care services processes. We found none, for example, that could tell us how many children and young people on child protection plans were also known to probation. Similarly, with the exception of Nottingham City, we saw none that related to children and young people working with YOTs. As YOT Management Boards were generally concentrating on offending behaviour, this left a potential gap in the strategic overview of the specific safeguarding needs of children and young people who have offended.

Good practice example: the LSCB and children and young people who have offended

Bath & North East Somerset YOT have a Safeguarding Children in Custody policy and the YOT routinely monitors children and young people who have been kept in police cells overnight. This had been reported to the LSCB. The YOT had also produced a briefing on children and young people in custody for senior strategic managers. The LSCB has monitored an action plan to implement recommendations made by a joint thematic inspection report (*Who's Looking out for the Children?*¹¹) about children and young people held in police cells. **(Bath & North East Somerset YOT)**

Conclusion

- 4.21. The strategic management of safeguarding work within probation was inconsistent. In most areas senior managers were trying to raise the awareness of staff and the profile of the work, however, it was usually one amongst a number of responsibilities and not always a priority. Whilst they ensured that basic training had been delivered to staff, we saw little evidence of monitoring to ensure that skills were up-to-date. There has been an absence of a lead in this area of work from NOMS.
- 4.22. We could not see that YOT Management Boards were proactively exploring the specific safeguarding needs of children and young people who have offended. Nor could we find any evidence that their safeguarding outcomes were known or had been improved as a consequence of any action by the boards.
- 4.23. There was generally attendance by Probation Trust representatives at the main LSCB, although this was not without resource implications in some trusts, but the impact of probation was hard to detect in most areas. The attendance of YOT staff was variable, but again the impact of their contribution was not always visible.
- 4.24. Crucially, the lack of specific attention to probation and YOT issues in LSCBs meant that there was little or no information available to gauge how effective action had been to protect and keep safe the children and young people with whom these agencies were in contact.
- 4.25. It appeared that the agenda at most LSCB meetings was driven by children's social care services;

11 <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/whos-looking-after-children.pdf>

probation and YOT business was not always seen as integral. Where data was being collected and examined by the LSCB, it focused on children's social care services processes. The safeguarding issues faced by children and young people who have offended and the risks posed by adult offenders are not given enough consideration or weight. This impacts upon multi-agency working and as the changes brought about by the Government's *Transforming Rehabilitation* strategy gather pace it will be vital that not only YOTs, but the National Probation Service and Community Rehabilitation Companies engage effectively with these strategic issues.

Appendices

Appendix 1: Glossary

ACPO	Association of Chief Police Officers
ASSET	Structured assessment tool based on research and developed by the Youth Justice Board looking at the child or young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
CSSIW	Care and Social Services Inspectorate Wales
Child abduction warning notice	Safeguarding intervention aimed at protecting children from adults who are believed to put them at risk. They are issued under the Child Abduction Act 1984 for those under 16 years and the Children Act 1989 for those under 18 years AND in the care of the local authority
Estyn	HM Inspectorate for Education and Training in Wales
HIW	Healthcare Inspectorate Wales
HM	Her Majesty's
HMCPSP	HM Crown Prosecution Service Inspectorate
HMI Constabulary	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
ICPC	Initial Child Protection Conference: meeting at which the level of risk to a child is defined and plans are put in place to protect them where necessary
LDU	Local Delivery Unit: an operation unit comprising of a probation office or offices. LDUs are generally coterminous with police basic command units and local authority structures
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
MARAC	Multi-Agency Risk Assessment Conference: local arrangements for the protection of victims of domestic violence

MASH	Multi-Agency Safeguarding Hub: local centralised arrangements for initial safeguarding and child protection enquiries
NOMS	National Offender Management Service: The single agency responsible for both prisons and Probation Trusts
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
PSR	Pre-sentence report: for a court
Risk of harm to others	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
Serious Further Offence	when an offender is charged with an offence classified as a Serious Further Offence (serious sexual or violent offences), the Probation Trust conducts an investigation and review of the management of the case
VMP	Vulnerability Management Plan: used by YOTs to manage the identified safeguarding needs of individual children and young people
YJB	Youth Justice Board for England and Wales
YOT/YOS/YJS	Youth Offending Team/Youth Offending Service/Youth Justice Service

Appendix 2: Role of the inspectorate and code of practice

HMI Probation

Information on the Role of HMI Probation and Code of Practice can be found on our website:

www.justiceinspectors.gov.uk/hmiprobation

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of Probation
1st Floor, Manchester Civil Justice Centre
1 Bridge Street West
Manchester, M3 3FX

Appendix 3: References

- Department for Education (March 2013) *Working Together to Safeguard Children 2013. A guide to inter-agency working to safeguard and promote the welfare of children.*
- NOMS Public Protection Unit (September 2009) *Safeguarding Children – Checklist for Offender Managers*
- YJB (2013) *Case Management Guidance*
- YJB (2013) *National Standards for Youth Justice Services*
- Department for Education (2011) *The Munro Review of Child Protection: Final Report*
- HM Government *Children Act 1989 (Amended 2004)*
- Welsh Assembly Government *Safeguarding Children: Working Together under the Children Act 2004*
- ACPO and YJB (2010) *The YOT Police Officer Review and Role Development*
- YJB (2014) *The Role of the YOT Police Officer*
- NOMS Offender Manager and Public Protection Group (January 2014) *Probation Instruction 02/2014 Safeguarding of children and vulnerable adults – changes to disqualification order regime - access to information on barred status of offenders*
- Criminal Justice Joint Inspection (2011) *Who's looking out for the children? A joint inspection of Appropriate Adult provision and children in detention after charge.*
- YJB (2013) *Corporate Plan 2013-2016 and Business Plan 2013/2014*

Appendix 4: An example of a Safeguarding Children Checklist

RESTRICTED

London
Probation Trust



APPENDIX 3

SAFEGUARDING CHILDREN CHECKLIST

When conducting an interview with the offender, it is imperative to include the assessment of possible safeguarding children concerns in order to include these in any risk assessment, risk management plan and sentence plan. Below is a quick checklist to assist in doing an initial assessment to decide if a further check is required from Children's Social Care or not: *(Please note this is not a comprehensive assessment, just a checklist to alert you to any possible safeguarding children concerns that need to be further investigated and assessed. Any "YES" should lead to a Safeguarding Children Check)*

1. Are you living with children (including siblings under 18 years)?
Yes / No

If yes, please comment how they are related to you:

2. Do you have overnight contact with children who are not normally living with you, or any other significant contact with other children (e.g. nieces, nephews, stepchildren from previous relationships)?
Yes / No

If yes, please give details:

3. Do you have any parental responsibilities? Yes / No
If yes, what is the nature of your parental responsibilities and what is your child(ren)'s age group?

4. Do your child(ren) have contact with the Police, gangs, social workers, etc?
Yes / No

If yes, please give details:

5. Is your child(ren) excluded from school? Have they been previously excluded from school?
Yes / No

If yes, please give details:

6. Were your child(ren) present when you committed this or previous offence(s)?
Yes / No

If yes, please give details:

RESTRICTED

31

APPENDIX 4

SAFEGUARDING CHILDREN CHECK

Request for Information from Children's Social Care

TO: Children's Social Care, London Borough of	FROM: London Probation Trust
Address:	Offender manager:
Telephone:	Address:
Fax:	Telephone:
Email:	Fax:
	Email:

Name of Defendant:

(including known aliases)

Date of Birth:

Home Address:

Bail Status:

(including bail address, if different to home address)

Name(s) and date(s) of birth of Child/ren and Adults who also reside at the above address, and names of other children who have significant contact with the offender:

Name	Age/D.O.B	Relationship/contact with offender <small>(Incl address if different to offender's)</small>	School/nursery/college (if known)

RESTRICTED

London
Probation Trust



London Probation Trust is currently involved in a statutory capacity with the above named. We would be grateful if you would complete the form below and return it by fax.

Please mark it for the attention of :

Please ensure that it is returned as soon as possible in order to ensure the offender manager is in a position to complete a meaningful assessment regarding any Safeguarding Children concerns for the courts and the risk management plan.

Sent by:

Position:

Signature: **Date:**

Please complete the questions below:

Is the defendant known to Children's Social Care? If so, in what capacity?	Please select	
Are the children known to Children's Social Care who reside or visit this address?	Please select	
If so, what is the nature of your contact with them (e.g Child Protection Plan, Section 17 support)		
Date Child made subject to Child Protection Plan. (if applicable)		Name of Social Worker Involved: Contact Tel No:

RESTRICTED

33

ISBN: 978-1-84099-