



Safeguarding Children

A joint Chief Inspectors' Report on Arrangements to Safeguard Children



Chief Inspector of Social Services



Director for Health Improvement, Commission for Health Improvement



Her Majesty's Chief Inspector of Constabulary



Her Majesty's Chief Inspector of the Crown Prosecution Service



Her Majesty's Chief Inspector of the Magistrates' Courts Service



Her Majesty's Chief Inspector of Schools



Her Majesty's Chief Inspector of Prisons



Her Majesty's Chief Inspector of Probation

SAFEGUARDING CHILDREN

A JOINT CHIEF INSPECTORS' REPORT ON ARRANGEMENTS TO SAFEGUARD CHILDREN

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Enquiries about this report should be addressed to:

Corporate Development Team
The Directorate for Children, Older People and Social Care Services
Department of Health
6th Floor, Wellington House
133-155 Waterloo Road
London SE1 8UG
Telephone: 020 7972 4437

Further copies may be obtained from:

Department of Health Publications
PO Box 777
London
SE1 6XH
Fax: 01623-724524
Email: doh@prolog.uk.com
Response line: 08701 555 455



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1 Introduction and Summary

Introduction

1.1 The welfare of our children and young people is crucial to the future well-being of our society. We know that abuse and neglect in childhood can cause long-lasting damage with consequences into adulthood.

1.2 The safety and welfare of children has been of increasing public concern over the past 50 years. Numerous inquiries into the circumstances of the tragic deaths of children at the hands of their parents, carers and professionals have identified failings in arrangements to protect children and promote their welfare.

1.3 The Government made a commitment in the 1998 White Paper *Modernising Social Services (2)* to put in place new arrangements to commission from all its Chief Inspectors of services involved with children a joint report on children's safeguards. These reports will be produced every three years.

1.4 This is the first of those reports. It draws on the work of:

- the Social Services Inspectorate (SSI);
- the Office for Standards in Education (OFSTED);
- the Commission for Health Improvement (CHI);
- Her Majesty's Inspectorate of Constabulary (HMIC);
- Her Majesty's Inspectorate of Probation (HMIP);
- Her Majesty's Magistrates' Courts Service Inspectorate (HMMCSI);
- Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI); and
- Her Majesty's Inspectorate of Prisons (HMIP).

1.5 The term safeguarding has not been defined in law or government guidance. It is a concept that has evolved from the initial concern about children and young people in public care to include the protection from harm of all children and young people and to

cover all agencies working with children and their families. We have taken the term to mean:

- **all agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's welfare are minimised; and**
- **where there are concerns about children and young people's welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies.**

1.6 We have included within this definition the responsibilities of agencies, particularly the police and probation services, in respect of potentially dangerous persons who present a risk of harm to the public, including children.

Sources of Evidence

1.7 This report draws on the findings of a wide range of inspection activity undertaken by individual inspectorates. In addition, a joint inspection was undertaken to address inter-agency arrangements for safeguarding children.

1.8 The joint Children's Safeguards inspection was undertaken by a team of inspectors from the eight inspectorates. We undertook fieldwork in eight local authority areas. The details of the standards and criteria and methodology are contained in the Appendices.

1.9 We were concerned to see how well all the agencies protected children from the risks of harm caused to them by their parents, carers or professionals. We also looked at how they were protected from other children, young people and people who are known to present a high risk of harm to them.

Arrangements by Agencies for Safeguarding Children

Summary of Findings

1.10 All agencies accepted that they have a fundamental responsibility to ensure that children are safeguarded, and in most cases this was backed up with a firm commitment by senior managers to ensure that their agencies did so.

1.11 Local agencies tend to interpret their safeguarding responsibilities in different ways or with different emphases. There have been important recent developments in legislation and in national guidance for some agencies relevant to aspects of safeguarding children. However, the priority given to safeguarding has not been reflected firmly, coherently or consistently enough in service planning and resource allocation nationally or locally across all agencies. Other priorities have competed for attention with action on safeguarding. The priority that senior staff said was given to safeguarding children was not reflected in many agencies' business plans.

1.12 In the areas where we were most confident of the safeguarding arrangements, we found senior managers who were committed to protecting children and who communicated their commitment through their organisations. They ensured that their staff were child-focused and kept the safeguarding of children high on the agenda at all times.

1.13 In these areas there was an open culture between local agencies and good direct lines of communication between senior managers. They had sufficient trust and confidence in each other to accept and address concerns brought to their attention.

Responding to Welfare Concerns

1.14 We were satisfied that in the vast majority of individual cases that we examined, the children were protected from the risks of further harm. In all authorities, children on the child protection register were allocated to social work staff, who were working well with professionals from other agencies.

1.15 We found good working relationships between almost all local agencies at all levels in most areas we inspected. However, many services were under pressure and experiencing major difficulties in recruiting and retaining key skilled and experienced staff. This was having a major impact upon safeguarding arrangements for children and young people.

1.16 In most areas, there was a high level of understanding, sympathy and support for those services under pressure, provided that senior managers were open with other agencies about their

difficulties and entered into discussion and dialogue with them about how they were managing the services. Agencies worked together flexibly to maintain crucial services to safeguard children.

1.17 However, in areas where there were long-standing tensions between agencies and less co-operation, it was difficult to achieve the necessary level of inter-agency commitment to ensure that arrangements to safeguard children were effective.

1.18 Many staff from all agencies were confused about their responsibilities and duties to share information about child welfare concerns with other agencies, and were not confident about whether other agencies shared information with them. As a consistent finding of inquiries over past years has been about weaknesses and failings in information sharing, this is a serious concern. There were very few formal agreements between agencies about how and when information should be shared.

Thresholds for Responding to Child Welfare Concerns

1.19 In most areas there were serious concerns amongst staff of all agencies about the thresholds that social services were applying in their children's services. Professional staff from other agencies considered that social services were not providing an adequate response when they judged a situation did not involve a high risk of serious harm to children and young people. Equally, they considered that social services did not provide adequate guidance, advice and support when they raised concerns about the welfare of children and young people. Many of these difficulties were explained by staff shortages within children's teams in social services.

1.20 In some areas we found that there was reluctance by some agencies to refer child welfare concerns to other agencies: teachers to social services, and social services and others to the police. Where this occurred, the local Area Child Protection Committee (ACPC) had not actively addressed those concerns.

1.21 We were advised that some specific services did not appear to be well integrated into the local safeguarding arrangements. These included GPs, child and adolescent mental health services, adult mental health services, some independent schools, NHS Direct and walk-in health centres.

1.22 The quality of care and responses to safeguarding issues for many children living away from home varied very considerably in different parts of the country. This applied to children in family placements, children's homes and residential schools. The participation of children and parents in reviews, the frequency of social worker visits to children looked after and the availability of and

access to independent visitors and advocates were not of a consistent quality. The care and protection of children and young people placed in secure accommodation was generally found to be of a good standard.

The Leadership of the Area Child Protection Committee

1.23 We found that few ACPCs were equipped and able to exercise their responsibilities to promote and ensure safeguards for children and young people.

1.24 There were many factors that contributed to this. Strong leadership of the ACPC needed to be combined with the commitment of all local agencies to support its work.

1.25 In only two areas had this commitment been translated into effective joint funding arrangements to enable the ACPC to fulfil its responsibilities. These two areas were most aware of the need to do more to fulfil their responsibilities to safeguard children.

1.26 Local agencies did not generally accept that they were accountable to the local ACPC for safeguarding arrangements. ACPCs did not command the authority to require local agencies to report on how they undertook their safeguarding duties. As they are not statutory bodies, they were not required to account for their work.

1.27 Although ACPCs are expected to produce an annual business plan, some areas did not have a recent business plan. Those that did had rarely specified their objectives or provided evidence of local activities and the standards they set for their work.

Young People who Commit Offences

1.28 HMI Prisons inspectors have highlighted the very serious risks to the welfare of young people held in Young Offender Institutions (YOIs). Although young people in YOIs are amongst those at highest risk of serious harm, their safeguarding had not been addressed in most areas.

1.29 Few ACPCs had representatives from Youth Offending Teams (YOTs) on them, and therefore they were not actively addressing the needs of these particularly vulnerable young people. YOTs were working in relative isolation from other services, were not demonstrating a commitment to risk assessment of these young people, and focused upon offending behaviour at the expense of considering welfare needs.

Potentially Dangerous Persons

1.30 All areas had developed Multi-Agency Public Protection Arrangements (MAPPA) and Panels (MAPPPs). In the absence of

detailed national guidance, these had been developed in different ways. There was also confusion about terminology to describe different categories of offenders who present a high risk of harm to the public, including children. There were good working relationships between the police and probation services who took the lead for the MAPPA, but there was no consistency in how they addressed their tasks. MAPPPs and ACPCs did not have formal links addressing their common concerns in safeguarding children.

1.31 All areas were struggling to respond to unconvicted people who present a high risk of harm to the public, including children.

Reading the Report

1.32 The rest of this report sets out our recommendations and records the inspection findings.

1.33 The report draws on evidence from a range of inspection work. Where the text does not specify the source of evidence, it refers to the children's safeguards inspection. If the evidence relates to other inspection activity, the specific inspection is named and a reference number is provided. Further details of relevant reports can be found in the bibliography at Appendix G.

Clarification of Terminology

1.34 Area: we inspected safeguarding arrangements in eight local authority areas. In all eight, the local ACPC covered the same geographical area as the local authority, and so we use the term 'area' to refer to both.

1.35 Agency: we use the term 'agency' to cover the range of organisations, services and professional groups who provide services to children and their families.

1.36 Potentially Dangerous Persons: offenders and also unconvicted people who present a high risk of harm to the public, including children. This phrase has been used throughout this report in the absence of a commonly accepted definition. This is currently being addressed by the Home Office Dangerous Offender Steering Group.

1.37 Some, most: when referring specifically to areas inspected during the fieldwork, rather than repeatedly say X out of 8, we have used the shorthand where **some** refers to 3 or 4 and **most** refers to 5 or 6.



Good Practice

1.38 During the fieldwork, we came across many examples of good practice by different agencies. Some of these are recorded in the Good Practice boxes. The brief notes should enable those interested to find out more from those agencies.

Further Reports on the Children’s Safeguards Inspections

1.39 Individual Chief Inspectors and the Commission for Health Improvement (CHI) will produce separate reports specific to their services. Information about these will be made available on their websites.



2 Recommendations

The Department of Health, Home Office, Department for Education and Skills, and the Lord Chancellor's Department should:

- 2.1** Ensure the safeguarding of children is firmly and consistently reflected in national and local service planning.
- 2.2** Support and facilitate national and local agencies to recruit and retain sufficient levels of appropriately qualified staff, paying particular regard to the image, status, morale, remuneration and working conditions of specialist child protection staff.
- 2.3** Establish minimum expectations, standards and curriculum for child protection training as part of the core professional training of all professionals working with children and young people (e.g. teacher training, medical and health staff training, police training, etc.).

The Department of Health should:

- 2.4** Review the current arrangements for Area Child Protection Committees (ACPCs) to determine whether they should be established on a statutory basis to ensure adequate accountability, authority and funding.
- 2.5** Review the purpose of child protection registers and issue guidance to local authorities.

The Lord Chancellor's Department, the Home Office and Department of Health should:

- 2.6** Ensure that there is clear guidance provided to all agencies under their respective responsibilities on the implications of the Data Protection Act 1998 and the Human Rights Act 1998 and other relevant law, in respect of sharing information about children where there are welfare concerns.

The Department of Health and the Home Office, with the Youth Justice Board, should:

2.7 Issue immediate guidance to ensure that local Youth Offending Teams (YOTs) and the Crown Prosecution Service (CPS) are invited to become full members of all ACPCs.

The Home Office and the Youth Justice Board should:

2.8 Issue revised guidance to the prison service and the ACPC member organisations on the requirements and arrangements to safeguard children in prisons and Young Offender Institutions (YOIs).

The Home Office should:

2.9 Ensure that safeguarding children and young people is a national priority for police services and the National Probation Service as part of their public protection arrangements, and ensure that this priority is reflected in local service plans.

2.10 Review the current arrangements for Multi-Agency Public Protection Panels (MAPPPs) to identify whether they should be established on a statutory basis to ensure adequate accountability, authority, funding and consistency of practice.

2.11 Ensure that the relationship between MAPPPs and ACPCs is clarified.

2.12 Implement a national policy framework for public protection, including MAPPPs and wider children's safeguarding issues, as a matter of priority in order to develop a more consistent approach to the assessment and management of potentially dangerous people.

2.13 Issue a set of national standards and performance measures for police and probation services' joint management of potentially dangerous offenders.

All Relevant Inspectorates should:

2.14 Review their inspection activity to ensure that there is sufficient emphasis on examining arrangements to safeguard children.

2.15 Ensure that prior to the next report appropriate inspection activity has been undertaken on the following safeguarding areas:

- young offender institutions;
- residential independent schools;
- the impact of domestic violence on children;
- children looked after outside of their home authority;
- unaccompanied asylum-seeking children and the children of refugees and asylum seekers;
- children with disabilities;
- the work of YOTs;
- children living in all forms of residential care.

2.16 Ensure that the findings of the National Care Standards Commission in relation to arrangements for safeguarding children in residential and boarding schools and residential care for children and young people are included in future joint Chief Inspectors' reports.

Area Child Protection Committees with their Constituent Agencies should:

2.17 Develop integrated planning processes in partnership with MAPPPs to ensure that the safeguarding of children is an individual agency and inter-agency priority.

2.18 Review their constitution, membership, level of representation and funding arrangements to ensure that the committee is adequately resourced and fit for purpose to lead the children's safeguarding agenda across the area and in all relevant settings.

2.19 Ensure that there is an appropriate range and quantity of joint and single agency training to meet the needs of the workforce of constituent agencies (including non-specialist staff), relevant voluntary and independent organisations in their locality, and agree minimum expectations in terms of attendance and content of training.

2.20 Ensure that there are robust management information processes to support the monitoring, evaluation and auditing of local child protection procedures and practice.

2.21 Ensure that reviews of serious cases are undertaken on all appropriate cases within the timescales and expectations of Chapter 8 of *Working Together to Safeguard Children* (3), that reports are circulated appropriately and action plan recommendations are implemented.

2.22 Develop explicit arrangements for sharing information within a framework of joint protocols in order to strengthen the safeguarding of children.

2.23 Ensure that concerns about the safety of young offenders are identified and addressed in partnership with the local YOT, YOIs and prisons.

2.24 Review the local arrangements for maintaining and accessing the child protection register to ensure that relevant information is captured and used to maximise the safeguarding of children.

Social Services Departments should:

2.25 Review the thresholds for providing services, instigating child protection inquiries and convening initial child protection conferences in order to ensure that children are protected from harm, and ensure that there is a shared understanding of these thresholds across all local agencies.

Police Services should:

2.26 Review and clarify the role, remit, location and status of force child protection units to ensure that all abuse of children is dealt with to a consistently high standard.

Health Services should:

2.27 Ensure that pre- and post-recruitment checks are undertaken for all appropriate people working with children in the National Health Service (NHS).

2.28 Ensure that workforce plans adequately reflect the workload of child and adolescent mental health services and community paediatric services.

2.29 Establish clear lines of responsibility to ensure that there is:

- appropriate provision of and support for ‘designated’ and ‘named’ doctors and nurses;
- appropriate senior representation on ACPCs;
- the active involvement in and contribution of Primary Care Trusts (PCTs), including GPs, in the local arrangements to safeguard children;

- attendance by general and other medical practitioners at initial child protection conferences or the advance provision of written reports;
- adequate provision of specialist nurses and doctors to provide services to children looked after.

Local Education Authorities should:

2.30 Monitor the efficiency of arrangements in maintained schools to safeguard children, including the effectiveness of child protection procedures and training.



3 Context

Legislative Background

3.1 The statutory basis for current requirements, practice and inter-agency arrangements to protect and safeguard children is the *Children Act 1989* (4). The Act came into force on 14 October 1991, and the associated Regulations and Guidance, including *Working Together* (5) and its subsequent addenda (6,7,8,9,10 and 11), outlined the requirement to establish local Area Child Protection Committees (ACPCs). The Act strengthened the requirements on all the agencies involved in child protection, notably council social services and education departments, health communities and former health authorities, police and probation services, to promote and safeguard the welfare of children living in the community, to make enquiries in situations where children are believed to be at risk of significant harm and to take appropriate action to protect them from harm. Safeguards for children living away from home were also enhanced.

3.2 The Government's White Paper *Modernising Social Services* (2) outlined the three interlinked priorities for services for children and vulnerable adults – promoting independence, improving protection and raising standards. The *Care Standards Act 2000* (12), implemented in April 2002, introduced *National Minimum Standards* for the provision of care for children, within residential and family-based care. The Act also established the National Care Standards Commission in April 2002, whose functions include the registration and inspection of children's facilities and services, and provides for the creation of a Children's Rights Director.

Past Inquiries

3.3 During the 1990s there were a number of important inquiries which examined the past mistreatment and abuse of children in care. These resulted in detailed reports and recommendations that have been addressed by government and local agencies:

- *Choosing with Care* (13), Norman Warner's report published in 1992, made 83 recommendations on how to ensure that staff working in children's homes and residential schools are suitable for such employment
- *People Like Us* (1), Sir William Utting's 1997 report of the *Children's Safeguards Review*, made 20 principal recommendations

and 139 others to improve the safety and conditions of children living away from home.

- *Government's Response to the Children's Safeguards Review* (14), published in 1998, outlined detailed plans for changes to legislation, regulations and guidance for all agencies involved in caring for children and young people away from home.
- *Lost in Care* (15), the report of the *Waterhouse Inquiry* (established in 1998, following the disclosures of abuse of children in care in North Wales between 1974 and 1996), was published in February 2000. The report makes 72 detailed recommendations to address the Inquiry's findings.
- *Learning the Lessons* (16), the Government's response to *Lost in Care*, was presented to Parliament in June 2000.
- In March 2002, following up from the *Waterhouse Inquiry*, a report of an inquiry by Lord Carlisle (17) into child protection in the NHS in Wales identified within the NHS a range of concerns and failings within the NHS to protect children.

Quality Protects and Working Together

3.4 Following the Utting Report and increasing evidence of poor outcomes for children in need and children looked after in particular, including the findings of the SSI inspection report *Someone Else's Children* (18), the Government introduced a major new initiative to improve services and outcomes for children. The Secretary of State for Health launched the *Quality Protects* (19) programme on 21 September 1998, setting new national objectives, standards and outcomes for children in need; and creating a new special children's grant to fund these improvements.

3.5 In 1999, the Government issued revised guidance on child protection. *Working Together to Safeguard Children* (3) is a guide to inter-agency working to safeguard and promote the welfare of children. It was issued jointly by the Department of Health, the Home Office and the Department for Education and Employment and it provides a national framework within which local agencies can implement their own detailed ways of working together. It also revised and clarified the roles and responsibilities of local ACPCs as detailed in Appendix E.

3.6 This guidance was followed in 2000 by the issuing of the *Framework for the Assessment of Children in Need and their Families* (20), again a joint publication between the Department of Health, DfEE and the Home Office. It provides a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider

context of the community in which they live. It was designed to enable clear professional judgements to be made by social workers and others as to whether the child is in need of services, whether the child is suffering or likely to suffer significant harm and what actions must be taken, or services provided, to respond to the needs of the child and his/her family.

3.7 In May 2000, the Department of Health, Home Office and DfEE issued supplementary guidance to *Working Together to Safeguard Children* entitled *Safeguarding Children Involved in Prostitution* (21). It sets out an inter-agency approach to safeguarding children who are or are likely to be abused through prostitution. The aim of the guidance is to both safeguard and promote the welfare of children, and to encourage the investigation and prosecution of criminal activities by those who coerce children into and abuse them through prostitution. A further supplement was issued in draft in 2001, *Safeguarding Children in whom Illness is Induced or Fabricated by Carers with Parenting Responsibilities* (22). Also, a *National Plan for Safeguarding Children from Commercial Sexual Exploitation* (23) was published.

Criminal Justice Legislation

3.8 Complementing policy changes in child protection there have been developments in criminal justice legislation aimed at protecting children and other vulnerable people. They include the following:

- *Sex Offenders Act 1997* (24), which established the requirement for specified sex offenders to register with the police;
- *Crime and Disorder Act 1998* (25), introduced the Sex Offenders Order giving the police powers to monitor those subject to them;
- *Protection of Children Act 1999* (26), implemented in October 2000 strengthened previous Local Authority Circulars regarding disclosure of criminal backgrounds of those with access to children;
- *Criminal Justice and Courts Services Act 2000* (27), which, as well as establishing the National Probation Service (NPS) and the Children and Families Court Advisory and Support Service (CAFCASS), placed a requirement on police and probation services to set up joint arrangements for the assessment and management of offenders at high risk of causing serious harm. Initial guidance setting out the minimum requirements for these arrangements was issued in March 2001.

Other Recent Policy Initiatives and Developments

3.9 These include:

- issuing by the Home Office in 2000 of a draft Child Protection Annex to all prisons to meet the recommendations of the *Children's Safeguards Review* (1). Governors of Young Offender Institutions (YOIs) were required to liaise with ACPCs and establish in-house child protection protocols and committees. This is to be strengthened by the development of further child protection guidance for YOIs;
- transfer of pre-sentence and supervision responsibilities for all offenders aged under 18 years (both within the community and in custody) to the Youth Justice Board (YJB) and Youth Offending Teams (YOTs) in April 2000;
- establishment of a Children's Taskforce in October 2000 to drive forward the modernisation of NHS and social care services for children and develop the National Service Framework (NSF) for children. The NSF will provide a comprehensive set of expectations and standards across health and social care settings. Six key areas have been implemented: acute hospital services, health promotion, disabled children, child and adolescent mental health services, children in special circumstances and maternity services;
- issuing of guidance to councils entitled *Planning and Providing Good Quality Placements for Children in Care* (29) in March 2001;
- publication of *The Education of Young People in Public Care* (30) by DH and DfES in 2001 supported by *Raising the Attainment of Children in Public Care* (OFSTED 2001) (28);
- publications by OFSTED during 2001–02 on education inclusion, school attendance and behaviour, including bullying;
- establishing specialist child protection coordinators to promote and support good practice in dealing with allegations against education service staff through DfES;
- publication in 2001 of a guide for young people looked after called *Your Life, Your Future* (31);
- implementation in October 2001 of the *Children (Leaving Care) Act 2000* (32) and associated regulations and guidance aimed at improving the life chances of care leavers;
- publication by the Department for Education and Skills (formerly DfEE) of *National Standards for Under Eights Day Care and Childminding* (33), to form the basis of the new regulatory

powers of the Early Years Directorate within OFSTED as of 1 September 2001;

- issuing in 2001 of initial guidance on sections 67 and 68 of the *Criminal Justice and Court Services Act 2000* (27), covering minimum requirements of MAPPPs (see Appendix F);
- issuing in 2001-2002 of a series of new standards for the provision of care within a range of settings, including boarding schools, children's homes and foster care, by the National Care Standards Commission;
- issuing of guidance by DH on *Child Protection Responsibilities of Primary Care Trusts* (34) in January 2002 and other circulars;
- development and implementation of a joint prison and probation offender assessment tool which includes specific assessment of risks to children;
- introduction of accredited programmes for work with sex offenders, many of whom target children, delivered in both prison and the community;
- publication of *Achieving Best Evidence in Criminal Proceedings* (35) in January 2002;
- announcement of a DH review of the legislative framework for private foster care (Part IX of the Children Act 1989) in January 2002;
- the establishment of *Choice Protects* (36) – a major review of fostering and placement services in March 2002;
- publication of the National Boarding Standards in March 2002, which were the result of collaborative work between the sector, the Department of Health and others;
- the Education Act 2002 places an explicit duty on LEAs and governing bodies of schools and Further Education institutions to safeguard and promote the welfare of children;
- the Education Act 2002 also sets new standards for the registration of independent schools, requiring all independent schools to have appropriate arrangements in place to secure the welfare, health and safety of pupils. Independent schools will have to meet the requirements of DfES guidance on child protection which flows from the changes introduced in the maintained sector.

The Role of the Key Agencies in Safeguarding Children

3.10 The death in 2000 of Victoria Climbié, after months of neglect and mistreatment by her carers, led to their conviction for murder in January 2001. Following this conviction, the Government announced the establishment of an independent statutory inquiry into the circumstances that led to the death of this eight-year-old child. The inquiry was unique in that it was established under three separate statutes and looked in particular at the roles played by police, social services and the health service in this case. Lord Laming was appointed to lead the inquiry team.

3.11 Social Services: Local councils with social services responsibilities have the lead role in responding to children in need and ensuring that all agencies work together to protect children from significant harm. The Director of Social Services within each council is responsible for establishing the local ACPC (see Appendix E for more details) and leading the planning process for children's services.

3.12 Social workers take a lead role in:

- responding to children and families in need of support and help;
- undertaking enquiries following allegations or suspicion of abuse;
- undertaking initial assessments and core assessments as part of the *Assessment Framework* (20);
- convening strategy meetings and initial and subsequent child protection conferences;
- court action to safeguard and protect children;
- coordinating the implementation of the child protection plan for children on the child protection register (CPR);
- looking after and planning for children in the care of the council;
- ensuring that children looked after are safeguarded in a foster family, children's home or other placement.

3.13 To fulfil these and their other duties, social services staff work in partnership with police officers, teachers, health personnel and all other relevant professionals and agencies.

3.14 Local Education Authorities (LEAs), schools and day care services have a key role to play in safeguarding children. The health, safety and welfare of children are central to all educational provision whether it is in pre-school day care, primary, secondary or residential schools. All schools are expected to have policies and procedures for

child protection. In addition, other responsibilities relevant to safeguarding children include what is done to promote good attendance, to manage behaviour and tackle bullying and other forms of harassment, and to provide effective personal, social and health education. Specific attention should be given to groups at risk of low achievement, including children in public care and with special needs, within the context of a general approach to educational inclusion.

3.15 LEAs are core members of each ACPC and are responsible for ensuring that maintained schools, staff and governors are fully integrated in and familiar with local multi-agency child protection procedures. They also have specific responsibilities for the health, safety and welfare of pupils and for related issues such as attendance, behaviour and provision for pupils out of school. LEAs need to work with their partners, including social services, police and health, in fulfilling their responsibilities.

3.16 The Police Service has a commitment, under the *Children Act 1989* (4), to protect children from abuse. However, this responsibility of protection also extends to other policing duties such as protecting the interests of child witnesses, exercising powers in connection with ‘care’ issues, missing children, and children who offend, proactive operations against those who exploit children including child sex abusers and curbing child prostitution and child pornography. The police service also has a role to protect children from sexual abuse through the management and monitoring of sex offenders, using a process of risk assessment and Multi-Agency Public Protection Panels (MAPPPs). Many of these duties are carried out in partnership with other agencies, principally but not exclusively with the social services, and within the framework of *Working Together to Safeguard Children* (3).

3.17 The Health Service plays an important role in safeguarding children. Health professionals ensure that children and families receive the care, support and treatment they need in order to promote children’s health and development. The universal nature of health provision means that they are often the first to be aware that families are experiencing difficulties. Until April 2002 health authorities were core members of each ACPC; their place is now taken by Primary Care Trusts (PCTs). The responsibility to appoint ‘designated’ doctors and nurses for child protection and ‘named’ doctors and nurses within each trust was also transferred from health authorities to PCTs.

3.18 PCTs should ensure the continuation of clear service standards for safeguarding children and promoting their welfare, which are

consistent with local ACPC procedures. The importance of children's safeguards is recognised to be key within NHS organisation planning and is addressed in:

- the NHS Plan (2000) (37);
- the forthcoming Children's National Service Framework (NSF);
- *Working Together to Safeguard Children* (1999) (3).

3.19 The NHS is required to employ designated leads in nursing and paediatric medicine to provide strategic focus on children's safeguards, usually on behalf of several NHS organisations, and serve on the main ACPC. Designated leads are usually supported by 'named' and specialist lead nurses and doctors within the NHS community. They assist with internal safeguards training, clinical supervision, audit and implementation of new procedures.

3.20 All NHS staff who have contact with children or provide services to children and their families owe a duty of care to safeguard and protect children by recognising and reporting situations of possible child abuse and, where appropriate, provide assessments and reports within the context of local child protection procedures. This includes general practitioners, child and adolescent psychiatrists, adult mental health professionals, midwives, health visitors, school nurses, paediatric nurses and paediatricians, and accident and emergency staff. Many other staff are affected, such as community and hospital-based health care practitioners and staff in ambulance NHS trusts, whose primary client focus may not necessarily always be the child.

3.21 Youth Offending Teams (YOTs): The Crime and Disorder Act 1998 (25) established that the principal aim of the Youth Justice Service (YJS) was the prevention of offending by children and young people. It required each local authority with social services and education responsibilities to establish YOTs as multi-disciplinary teams including probation officers, police officers, social workers and health and education workers.

3.22 The Youth Justice Board (YJB) was established to have oversight of these local arrangements. It has developed national standards for youth justice work and sets targets for local services.

3.23 The National Probation Service (NPS) was created in April 2001 by the *Criminal Justice and Court Services Act* (CJCSA) (27) forming a single service delivered through 42 local probation areas. National strategies and guidance are developed and issued by the National Probation Director. One of the service's principal aims is to

protect the public and in the context of safeguarding undertakes the following key tasks:

- assessment of offenders, particularly the risk of serious harm to children;
- provision of reports to courts and the Parole Board;
- supervision of offenders in the community on orders and licences including their enforcement;
- provision of accredited programmes including the sex offender treatment programme.

3.24 The *Criminal Justice and Court Services Act 2000 (27)* also placed a duty on the NPS, in collaboration with the police, to make joint arrangements for the assessment and management of the risks posed by sexual, violent and other offenders who may cause serious harm to the public. In order to do this they are required to establish local MAPPA (see Appendix F for more details). The work of the MAPPPs is overseen by the Home Office Dangerous Offenders Unit, which is staffed by police and probation representatives. The NPS does have a key role in safeguarding children by supervising offenders as part of its public protection brief.

3.25 The **Children and Family Court Advisory and Support Service (CAFCASS)** was established in April 2001 as a non-departmental government body (NDGB). It brings together in one organisation covering England and Wales, support services in family proceedings that had been previously provided separately, namely:

- the Family Court Welfare Service, formerly part of the probation service;
- the guardian *ad litem* and reporting officer service, formerly a responsibility of councils;
- the children's division of the Official Solicitor's Department as an Associate Office of the Lord Chancellor's Department.

3.26 The principal functions of CAFCASS are set out in the *Criminal Justice and Court Services Act 2000 (27)*. These are in respect of family proceedings in which the welfare of children is or may be in question, to:

- safeguard and promote the welfare of children;
- give advice to any court about an application made to it in such proceedings;
- make provision for children to be represented in such proceedings;

- provide information, advice and other support for children and families.

3.27 Since April 2001, CAFCASS has also become a core member of ACPCs, sharing in the wider safeguarding responsibilities outlined in *Working Together to Safeguard Children* (3).

3.28 The Prison Service has a key role in relation to safeguarding children within its establishments that hold young people under the age of 18. Since April 2000, the YJB has been responsible for contracting all secure provision for children and young people under the age of 18 either on remand or after sentence. The vast majority of these young people are placed in prison service establishments, with up to 2,900 boys being placed in 13 YOIs and four adult prisons with the capacity to hold up to 100 girls. These establishments are required to develop comprehensive child protection procedures covering circumstances where:

- young people disclose past abuse;
- young people are at risk from other prisoners;
- allegations are made against prison officers.

3.29 In addition, within the wider prison estate there is a need to work with others to protect children from dangerous offenders through:

- an appropriate response to any disclosure of abuse;
- communication and referral of concerns/allegations to social services and police;
- assessment of the risk offenders might pose to children;
- monitoring contact of prisoners with children through telephone, letters or visits.

3.30 The Crown Prosecution Service (CPS) advises the police on possible prosecutions and takes over prosecutions begun by police. It is responsible for the preparation of cases for court and for their presentation at court. It works in partnership with the police, the courts and other agencies throughout the criminal justice system. The role of the CPS is to prosecute cases firmly, fairly and effectively when there is sufficient evidence to provide a realistic prospect of conviction and when it is in the public interest to do so. These two criteria are the key principles to be applied in every case and they are embodied in the Code for Crown Prosecutors, which is issued under section 10 of the Prosecution of Offences Act 1985 (38). The Code

also provides guidance to prosecutors on the general principles to be applied in every case, although each case is decided upon its individual merits.

3.31 The CPS attaches particular importance to cases involving allegations of child abuse. There are three key principles of CPS policy in relation to child abuse cases: expedition; sensitivity; and fairness. CPS areas should ensure that child abuse cases are given preferential treatment in the review process; that intervals between the key stages of the prosecution process are the minimum, consistent with the completion of all relevant tasks; that high standards of timeliness are achieved; and that child abuse cases are dealt with by lawyers and caseworkers of appropriate experience.

3.32 The CPS recognises that a child victim or witness deserves special care and attention from the CPS in the conduct of his/her case, and that this is particularly so where the child is the victim of, or witness to, child abuse. Delay should be avoided in all cases involving a child victim or witness. Child witnesses should be afforded as much protection as may be necessary to enable them to give their evidence in a way that both maintains the quality of that evidence and minimises the trauma suffered by the child.

Arrangements for Preparing the joint Chief Inspectors' Report

3.33 Following the recommendation by Sir William Utting in *People Like Us* (1), the Government made a commitment in *Modernising Social Services* (2) that the Chief Inspector of the Social Services Inspectorate would, with all other relevant inspectorates, conduct a review and report on a three-yearly basis how well children are being safeguarded from harm. This report is the result of the first such review and includes a collation of relevant inspection findings over the last three years as well as the findings of a joint inspection of eight ACPC areas. Details of the role, remit and inspection programmes of the participating inspectorates and the methodology of the children's safeguards inspection can be found in the appendices.

3.34 Because of the timetable for the preparation of this report, it was not possible to include the work of the National Care Standards Commission, which was established in April 2002. The Commission has responsibility for inspecting children's homes, residential family centres, independent, voluntary and local authority fostering and adoption agencies and services, boarding schools and residential special schools. It is anticipated that their inspection activity will be included in future reports.

3.35 The inspectorates involved in this inspection and report are as follows:

- Social Services Inspectorate (SSI);
- Office for Standards in Education (OFSTED);
- Commission for Health Improvement (CHI);
- Her Majesty's Inspectorate of Constabulary (HMIC);
- Her Majesty's Inspectorate of Probation (HMIP);
- Her Majesty's Magistrates' Courts Service Inspectorate (HMMCSI);
- Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI); and
- Her Majesty's Inspectorate of Prisons (HMIP).



4 How Well Individual Agencies Safeguard Children

Introduction

4.1 All agencies working with children and families have a paramount responsibility to ensure that children are safeguarded. For some services, this is not stated overtly or supported by national policies and priorities.

4.2 We looked at the priority formally given to safeguarding children and child protection in agency policies, priorities and business plans. We sought to complement that through testing out in practice if the safeguarding of children was demonstrably a priority or not.

4.3 Recruitment of staff is a key safeguarding issue. We wanted to ensure that all appropriate checks were being made on staff prior to their appointment, and that police checks were being updated regularly.

4.4 The induction, training, supervision, support and monitoring of staff is also critical. We met with groups of front-line staff as well as their managers and senior managers, to find out how well agencies were managing staff within a safeguarding and child-orientated culture in their organisations.

4.5 Few agencies have agreed systems for workload measurement or defined standards for staff workloads. We looked at and considered the workloads that staff were having to carry, recognising that managers have responsibility for ensuring that services are maintained.

4.6 There are no nationally set standards for training in respect of safeguarding children and child protection work. There is no formal accreditation of training specific to child protection work.

4.7 We also look in this section at working relationships between staff from different agencies.

The Priority Given to Safeguarding Children

Findings

4.8 The safeguarding of children was recognised as a core responsibility by all agencies working with children and their families. This was clearly stated or acknowledged by senior staff in all agencies and those responsible for these services.

4.9 In most areas, this commitment by senior staff was communicated to and owned by staff throughout the agencies and demonstrated by the evidence of their support to services. However, in two areas we judged that this commitment was not backed up with an appropriate investment in or support to services to safeguard children. In these areas, the priority and support given was insufficient to develop a culture of safeguarding across agencies and services.

4.10 The importance of ensuring that services work to safeguard children was seen as fundamental by senior staff. However, there was less clarity about how this should be achieved. This was particularly evident from interviews with some of those responsible for local services: local politicians and National Health Service Trust board members, for example. In one case a group of local school governors interpreted the safeguarding agenda as being almost exclusively about security of school premises. Some local politicians did not perceive the safeguarding agenda as being wider than the Quality Protects agenda. Few recognised the crucial importance of a culture of safeguarding that pervaded all services and staff.

4.11 In contrast, senior school staff appreciated the serious implications of bullying as a safeguarding issue and its potential harm to children's welfare. A wide range of strategies were in place and being extended and implemented to engage with bullying behaviour. There was a commitment to tackle all bullying firmly and directly. This was alongside initiatives and strategies to improve attendance and behaviour, and priority given to improving the educational achievements of children and young people in public care.

4.12 The Crown Prosecution Service (CPS) policy is to attach particular importance to cases involving allegations of child abuse, with three key principles of expedition, sensitivity and fairness. There was a high level of commitment amongst CPS staff towards cases involving children, with a generally good level of liaison and joint training with police. In some areas, the link between domestic violence and the impact upon children was being seen more clearly in the wake of the revised CPS guidance on the prosecution of domestic violence cases. The guidance emphasises the importance of child welfare, which is a major consideration in deciding whether to prosecute in cases of domestic violence.

GOOD PRACTICE

Shropshire Council, with health staff, had developed a very successful project to help children and young people with emotional and behavioural problems and support their reintegration into mainstream schooling.

The Lack of Support to the Priority of Safeguarding Children at the National Level

4.13 Many chief executives and heads of service stated quite explicitly that the safeguarding of children was not included within the stated priorities for their agency services. They were clear that their priorities and agenda were set at a national level, and that they were driven by nationally set performance measures. On occasions we saw or heard evidence that resources normally primarily focusing upon safeguarding of children were diverted to high-profile local and national priorities.

4.14 This focus upon national priorities was reflected in local business plans that often failed to identify the welfare and safeguarding of children at all, let alone as a priority. Local education authorities demonstrated an appreciation of the key emphasis upon safeguarding, and that this should be within the context of wider services for children. They had developed a range of policies, strategies and systems which were relevant to safeguarding children, but these were rarely pulled together into a single overarching document or supported by an audit of action.

4.15 Child protection and potentially dangerous offenders did not appear in police force or crime and disorder plans as priorities. We found little evidence of chief police officers' engagement with safeguarding work.

GOOD PRACTICE

Stockport Primary and Public Services Directorate Plan for Health Services developed by the Primary Care Trust (PCT) detailed objectives and action plans that had specific reference to child protection issues.

Staffing and Services Under Stress

4.16 Many agencies were experiencing serious difficulties in recruiting and retaining suitably qualified and experienced staff. We found staff shortages in all the following services:

- social services;
- probation services;
- community paediatrics;
- child and adolescent mental health services (CAMHS);

- health visitors and midwives;
- some schools.

4.17 The problems were most acute within London and the South East, but were not confined to those areas. For social services, health visitors and midwives in particular, in London and the South East, agency staff filled some gaps in teams. In some county areas it was not possible to recruit temporary agency staff, and this left real gaps in services.

4.18 The consequences for children and young people were very serious. For example, some young people in care have reported in the past that they had had five or six social workers over the past year, and so had lost confidence in social workers and looked for continuity and consistency of planning to the chairperson of their reviews. (39 and 40) This was still a real concern at the time of this inspection.

4.19 The consequences for staff were also very serious. In many agencies, we found committed, experienced staff working under severe pressure. At times they found the demands of heavy workloads and covering the staffing vacancies overwhelming.

4.20 In more than one area, the health service was experiencing real difficulties in recruiting CAMHS psychiatrists, and other CAMHS professionals. There were also serious difficulties in recruiting community paediatricians, health visitors, midwives and appropriate resources for 'designated doctors' in some areas. There were difficult working relationships in certain paediatric services.

GOOD PRACTICE

Hammersmith and Fulham health visiting service was experiencing recruitment difficulties. They had undertaken a risk management exercise to try and address some of these difficulties and introduced a Saturday service for a deprived estate in White City.

4.21 The impact was similarly very serious on joint working.

4.22 The problems social services have been facing in recent years in recruiting skilled qualified social work staff have been well documented in previous inspection reports (39 and 40).

4.23 These reports also suggest some ways of addressing these difficulties, as they found that the problems of recruitment and retention were reduced where there was:

Recruitment

- a responsive management culture;
- good and open communication between staff and managers;
- good levels of staff supervision, support and training;
- career grade and/or senior practitioner posts;
- ‘golden handshakes’ and ‘golden handcuffs’;
- posts for family support workers which do not require qualifications but do ease the workloads of qualified social workers.

4.24 For some services it was evident that work in the area of child protection is regarded as low status. This was clearly an issue within the police forces, where staff working in specialist child protection teams often felt undervalued and that their work was not taken seriously by other members of staff.

Safeguarding Checks on Staff

4.25 In social services, education, the police and probation services, thorough arrangements were generally in place to check the background of all staff who were recruited on a permanent basis. Staff recruited by social services through agencies on a temporary basis were not always adequately checked. Schools sometimes experienced delays in checks of criminal records on newly appointed staff and systems were not robust in recruitment of staff through agencies.

4.26 There were serious concerns about the arrangements to check health service staff who have unsupervised access to children. We found that not all GPs and some other health staff had been subject to police checks prior to recruitment. There was a high level of confusion about the responsibility to undertake police checks in respect of established members of staff. Staff such as paediatricians who had been in post for many years often had not had initial or subsequent checks.

4.27 Social Services Inspectorate inspections (39, 40 and 41) include an examination of recruitment policies and practice within social services. All councils were found to have developed policies and procedures to check the suitability of staff working with children in line with the requirements of the Warner Report (8) and other government regulations and guidance. The implementation of such procedures was, however, inconsistent and variable.

4.28 Shortcomings in the systems for the recruitment of both staff and foster carers included:

- inconsistent recording of checks being carried out with the Department of Health Consultancy Index/Protection of Children Act List;
- not obtaining two separate references for new employees;
- not having any record of having examined proof of identity or qualifications;
- staff starting work and carers taking placements before all necessary checks had been completed;
- poor systems for tracking and recording the outcomes of checks; and
- variable interpretations between police forces of the implications of the Data Protection Act on the release of information.

4.29 The checking of residential staff was better than that of fieldwork staff and was largely Warner compliant. The SSI inspection of foster care services, *Fostering for the Future* (41), found that some councils had closer scrutiny of staff employed in children's homes than for those who had other substantial access to children. Inspections by the SSI of the work of council registration and inspection units, secure units and voluntary children's homes have all had an emphasis on ensuring that recruitment checks on staff joining residential establishments are rigorously undertaken.

GOOD PRACTICE

Shropshire Health Authority had commissioned an audit in some GP practices to clarify which staff had been vetted. This was being extended through other practices.

Training

4.30 Most agencies look to the Area Child Protection Committee (ACPC) to provide basic child protection training to complement their own induction programmes for staff working in this field. We found some good examples of the provision of basic awareness training in most areas.

GOOD PRACTICE

Hammersmith and Fulham, Stockport, and Nottingham ACPCs in particular, provided good basic awareness training for staff from a wide range of agencies including voluntary agencies. Nottingham had imaginatively provided training sessions in the evening and at weekends to accommodate the needs of different groups of staff.

Surrey ACPC had organised Beyond Belief conferences. One was specifically aimed at independent schools and the others at local authority schools. They covered policies and procedures, experiences of child protection investigation in schools, characteristics of sex offenders and the dangers of the internet.

Hammersmith and Fulham had provided specific roadshows to encourage GP participation in child protection training.

4.31 Health communities generally had good access to a range of internal and accredited courses. Few of these courses were multi-agency to address the local safeguarding issues. A few areas were exploring the scope to formally accredit training for staff working in child protection, but this was rarely well developed. The potential of formal accreditation was widely recognised, and it was thought this would address some of the current concerns in respect of participation.

4.32 Most staff reported that they did not receive sufficient refresher training to ensure that they maintained high standards of practice. There was also concern that there was not sufficient specialist training.

4.33 We found that weaknesses regularly reported included:

- very few teaching staff, apart from the designated coordinators, attended centrally organised child protection training, although many received school-based training;
- GPs rarely attended child protection training: even when innovative courses had been organised at lunchtime, evenings or prior to surgery;
- training for court staff was very limited;
- uniformed police officers were not receiving any basic child protection training or training in respect of work with potentially dangerous offenders;
- training for staff working with potentially dangerous offenders, including sex offenders, had been very limited prior to staff taking up new responsibilities in these areas.

Working with Other Agencies

4.34 There were good working relationships between staff in different agencies at most levels in most areas. This was supported by a lot of genuine goodwill between managers and staff at all levels.

4.35 Good working relationships between front-line staff were clearly enhanced and supported by regular good quality multi-agency child protection training. Specific training methods, such as using case scenarios, were particularly beneficial.

4.36 Positive examples included:

- good working relationships between specialist child protection police teams and their equivalents and social services colleagues;
- good working relationships between specialist child abuse crown prosecutors and specialist child protection police teams;
- good support to health communities and other agencies from 'designated' and 'named' professionals in child protection;
- impressive co-operation and collaboration between police and probation services at all levels and in all areas in respect of work with potentially dangerous offenders who pose a risk of harm to the public, including children;
- effective working relationships between health professionals and social workers, although this could be over-dependent upon personalities.

4.37 It was very evident that the specialist police officers working in child protection have developed experience and skill in investigative work that has earned the respect of social workers. Her Majesty's Inspectorate of Constabulary's (HMIC's) *Thematic Inspection of Child Protection* (42) found that police officers led most Memorandum of Good Practice video interviews. Their work was skilled, and their lead role was appropriate and effective.

4.38 Relationships between social services and health were complex. In many areas there were good working relationships between health visitors, community paediatricians and social workers. These were being seriously jeopardised in some areas due to the extent of staffing changes, particularly as a result of the current reforms within the NHS. Personal contacts remained important, and health visitors, in particular, valued contact with an identified social worker. In some areas, health visitors reported that they felt they had to undertake the social worker's role due to staffing difficulties within social services.

4.39 There was widespread concern that GPs did not attend initial child protection conferences or multi-agency training, and made little contribution to the whole safeguarding agenda. There was particular difficulty in encouraging GPs to be active on ACPCs or to undertake their child protection responsibilities. Some GPs reported that they were confident that the health visitor could report their concerns on

their behalf at child protection conferences. We believe that this is inappropriate. GPs commented that they would have to fund locums to cover their clinics in order to attend child protection conferences, training courses and other ACPC activities. GPs also commented that safeguarding children was one of many services they were obliged to provide for a generic population.

4.40 Relationships between schools and social services varied considerably. Relationships between senior social services and education staff, particularly within the Local Education Authority (LEA), were normally better than those between social services and school staff. Relationships between school staff and social services were sometimes unduly influenced by past experiences and personal contacts.

Management of Performance

4.41 Staff from many agencies emphasised the importance of regular supervision. They saw it as a key element in maintaining quality and therefore safeguarding children. They reported that frequency and quality of supervision could vary. The quality of supervision was strongest within the probation service where it was backed up with regular appraisal.

4.42 We found wide variations in the workloads that staff and first-line managers were carrying. Many first-line managers were struggling with very high workloads as well as supervising staff.

4.43 In most areas, the Detective Sergeant responsible for management of specialist police teams was carrying a substantial workload, often comparable to that of her/his staff.

4.44 We found that the additional work required of 'designated' and 'named' health staff was hardly recognised. One doctor reported an allocation of 40 minutes per week for her child protection responsibilities, which included active membership of the ACPC and some of its sub-groups. Clearly this was not enough. Others were trying to provide other paediatric services over wide geographical areas while undertaking their contracted designated role in a few sessions.

4.45 The key responsibilities of first-line managers, particularly at times of staffing difficulties and vacancies, were not sufficiently recognised in any of the agencies. The responsibilities for the quality of decision making and recording and for case file auditing were not clearly defined. They received inadequate training and support for this complex and difficult work.

Conclusions

4.46 There was a clear commitment to the safeguarding of children by all key agencies. There was less consensus about the actions required to ensure that children and young people were safeguarded.

4.47 Safeguarding children is not a stated priority for many agencies at a national level, and so the commitment voiced by senior staff and leaders in organisations was often not reflected in local agency business plans or formal priorities. We recommend that government departments should ensure that the safeguarding of children is clearly identified as a priority at both national and local level.

4.48 There are performance measures relevant to safeguarding children in social services and education. These alone do not ensure quality services to safeguard children: safeguarding arrangements were most robust where leaders and senior managers demonstrated an active commitment to children's welfare, and were constantly vigilant and challenging their staff and organisations to strive to improve the quality of services. For other agencies, there were no relevant performance measures, and the pressures from other local and national priorities could compromise the commitment to safeguard children by diverting resources to address these priorities.

4.49 In most agencies, there were many committed staff who were working extremely hard to promote the welfare of children. All key agencies were experiencing severe difficulties in recruiting and retaining experienced and skilled staff in some areas. This was having a severe impact upon the quality of services and inter-agency collaboration. Some staff were overwhelmed by heavy workloads and covering for staff shortages. The recruitment crisis in some services posed a severe risk that agencies would not be able to sustain acceptable standards of work to safeguard children in some parts of the country.

4.50 The quantity and quality of training for staff working in child protection services varied widely. Multi-agency courses were poorly supported by many agencies, and training courses were not accredited. This needed addressing.

4.51 The collaboration between the police and probation services at all levels and in all areas in respect of work with potentially dangerous persons and child protection investigations was impressive.

4.52 The 'designated' and 'named' lead medical staff provided a vital and valued link between trust board members and operational

staff across health services, and this was appreciated by trust staff and other agencies. However, there was widespread concern that most GPs were not participating in local safeguarding arrangements and were not perceived as being committed to the safeguarding agenda.

4.53 First-line managers play a crucial role, and in many agencies they were not receiving adequate training and support to fulfil their role, and lacked the capacity to undertake regular audits of the work of their staff.

4.54 Safeguarding checks on staff were generally satisfactory, but the lack of recruitment checks on health staff was a serious concern. We recommend that health services ensure that recent guidance is followed for all staff (43).



5 Agencies Working Together to Safeguard Children

Introduction

5.1 Each local authority is required to establish an Area Child Protection Committee (ACPC) to conform with guidance set out in *Working Together to Safeguard Children* (3). The ACPC is charged with wide-ranging responsibilities to ensure that all local agencies working with children and families participate fully in arrangements to safeguard children. The specific responsibilities of the ACPC are set out in Appendix E.

5.2 We wanted to see how well the ACPC was fulfilling its responsibilities. We looked at ACPC business plans and funding arrangements. The ACPC is not directly accountable to any government department or local body. There is no national guidance on funding.

5.3 We also looked at how the ACPC was fulfilling its responsibility to raise awareness locally of safeguarding issues and explain to the wider community how it can contribute to safeguarding children.

5.4 We were particularly concerned to see if there was good communication between agencies and whether they could challenge one another about the safety of children. We checked that local arrangements were child-focused and that there was a strong culture to support the safeguarding and welfare of children.

Findings

5.5 All agencies recognised the importance of ensuring that children were safeguarded, and that it was a high priority. However, this did not necessarily result in effective joint arrangements at the local level.

5.6 We found that only a minority of ACPCs were well supported and led the safeguarding agenda across agencies effectively. In some

The Leadership of the Area Child Protection Committee

other areas, the ACPC had recognised that it needed to strengthen its role, and recent changes of leadership had resulted in a renewed determination to provide firmer leadership.

GOOD PRACTICE

Surrey County Council and Nottingham City Council had both established strong local commitments to support the work of the ACPC, and both were working well to create integrated plans for local services that embraced the safeguarding agenda. These were also the two areas where there were robust local funding arrangements for the work of the ACPC.

5.7 In the majority of areas, we found that the ACPC was a weak body that was not exercising effective leadership between agencies. We were particularly concerned to find that in two areas the local ACPC had been very poorly supported in the previous year and had become, we judged, almost totally ineffective. Recent initiatives had just begun to address those situations at the time of the inspection.

5.8 In these areas, the ACPC had not managed to engage local agencies sufficiently to address the range of tasks and responsibilities necessary to safeguard children. It had not managed to ensure that sufficient priority was given to safeguarding children in all local agencies, or to hold them to account.

Representation on the Area Child Protection Committee

5.9 There were wide differences in the membership of the ACPC. Representation was from different levels of seniority in constituent organisations, and some key agencies were not members. Membership varied between 12 and over 30 people.

5.10 The most significant omissions were:

- *Youth Offending Teams* (YOTs) were only members in a minority of areas, which resulted in a serious lack of engagement with young offenders in most areas.
- *GPs* were only represented on the ACPC in a few areas, which compounded the difficulty of gaining their commitment to the work of the ACPC and the local safeguarding agendas.
- *The Crown Prosecution Service* (CPS) were only members of half the ACPCs, and the importance of successful prosecutions of perpetrators for safeguarding children was not being adequately addressed by other ACPCs.

5.11 The *HMIC Thematic Inspection of Child Protection* (42) identified concerns that police representatives on ACPCs were not

always of a senior enough level to have sufficient decision making authority to ensure that ACPC initiatives were implemented. This was found to be particularly serious where boundaries were not coterminous between police forces and the ACPC.

5.12 In most areas, the probation service representatives were finding it difficult to identify a role and engage with the ACPC agenda. There had been no specific national guidance on child protection for many years. The problems in their role related in part to the difficulty all areas were experiencing in making effective links between the work of the ACPC and the Multi-Agency Public Protection Panels (MAPPPs), the local arrangements in respect of adults who present a risk of significant harm to other people, and specifically to children.

5.13 In areas in which there was a wide level of membership of the ACPC, the quality of inter-agency working tended to be higher, and there was evidence of higher levels of trust and confidence between ACPC members and related agencies. There may be issues of principle relating to the independence of the CPS and its decision-making in individual cases and, additionally, practical issues relating to geographical coterminosity, frequency of meetings, and the degree to which the CPS can contribute to the substance of ACPC work. We found that membership of the ACPC by the CPS was beneficial, whether by way of full attendance at all ACPC meetings or where there was input on appropriate and relevant issues.

5.14 Representation from the local health community presented particular challenges in many areas. The local health organisational arrangements were undergoing major change at the time of the inspection, and this had created some lack of continuity in representation from health agencies and concerns about future representation. Primary Care Trusts (PCTs) were just being established, but many ACPCs had not managed to engage the participation of a general practitioner representative. Despite this, in some areas, there was concern that the health community could dominate the agenda of the ACPC, because of the number of representatives, and that this could increase in the near future in the light of NHS reforms introduced on 1 April 2002.

5.15 From April 2001, the Children and Family Court Advisory and Support Service (CAFCASS) became a core member of local ACPCs. Due to the many other issues that CAFCASS had faced in its first year, the responsibility to participate in the work of the ACPC had not figured as a priority in regions or at headquarters. It was apparent that they had yet to establish their role and contribution to the work of the ACPC.

5.16 ACPCs did not always engage representatives from agencies with sufficient seniority and authority to commit resources and ensure integrated planning and a commitment to safeguarding throughout their organisation.

5.17 In the larger county areas, there was normally a number of local ACPCs with representation from local services. These bodies could undertake some audit work, from the perspective of knowledge of local services. However, we found that in the majority of cases their links to the main county ACPC were poor.

5.18 The lack of coterminosity between ACPCs and the police, probation and court services compounded the difficulties over representation on ACPCs. This was a major issue in London, where the Metropolitan Police Force had to relate to 32 different ACPCs with their different procedures and meetings. It was also an issue in the rest of the country, where these services cover several ACPC areas.

Funding the Work of the Area Child Protection Committee

5.19 There were different local arrangements to fund the work of the ACPC. The resources were only adequate to support the full range of responsibilities in two areas. One had a budget of over £110,000 per annum, and this was due to increase to over £140,000 in the current year. The ACPCs that were relatively well resourced were also the ones that were seeking to increase the funding to enable them to address their task more effectively, as they were the ones most aware of the limitations of what they could achieve under existing arrangements for the ACPC.

5.20 This contrasted sharply with the resources available to most ACPCs, which were of the order of £10,000 to £35,000 per annum. We judged this to be seriously inadequate, as there were very limited, if any, resources to employ an administrator to support the work of the ACPC, let alone to undertake tasks on its behalf.

5.21 One ACPC did not have the finances to publish their own child protection procedures, and had to charge organisations for copies: for voluntary organisations this was a serious disincentive to engage with the procedures.

5.22 In some areas, some agencies acknowledged their responsibility to fund the work of the ACPC but had not done so because local funding arrangements had not been agreed.

Raising Awareness Locally of the Safeguarding Agenda

5.23 We met with groups of representatives of local voluntary organisations and found that in most cases they had no knowledge of the work of their ACPC. Few had managed to raise the profile of their

work locally, or to make any significant impact upon the local community.

GOOD PRACTICE

Kent ACPC had conducted a high-profile publicity campaign to warn parents of the dangers of shaking babies.

Surrey ACPC produced regular newsletters that received wide distribution and raised the profile of its work locally.

Joint Planning and Integrated Services

5.24 In some areas, we found that there were very positive efforts being made to develop integrated local plans between agencies to promote a range of services to safeguard children and promote their welfare. It was no coincidence that these were most evident in the areas where there were strong commitments to the work of the ACPC, backed up with financial contributions from different agencies.

5.25 In most areas, social services were focusing planning resources on the Quality Protects Management Action Plans, and this was at the expense of their Children's Services Plans and leading inter-agency planning.

5.26 It was particularly evident that the work of local domestic violence forums in most areas was detached from the work of the ACPC. We found that generally there were active domestic violence forums, but the importance of close links with and coordination with the work of the ACPC had not been recognised or had not been addressed. This was despite the fact that domestic violence forums are required to be members of local ACPCs.

5.27 Similarly, we found that the local MAPPAs had been developed quite independently of the local safeguarding arrangements and that formal links had not been established. In most areas there was a strategic forum for agreeing and overseeing the operation of the MAPPAs, with representation from the police and probation services, and other services at a high level. These were often the same representatives on the ACPC. Therefore the opportunity to establish formal links was there but was not being realised.

5.28 Neither child protection nor work in respect of dangerous offenders appeared as a priority in police business plans or local crime and disorder strategies.

The Area Child Protection Committee Business Plan

5.29 In several areas, there was no recent ACPC business plan. In some other areas, the plans were not robust, and did not identify or clearly formulate objectives and set out strategies to meet them. Where detailed business plans existed, this helped focus the work of the ACPC and the monitoring of progress.

5.30 Data to enable ACPCs to review their effectiveness was particularly weak in most areas. In general, ACPCs had not established arrangements for routine reporting by local agencies and authorities. There were few expectations that agencies other than social services reported to the ACPC. Even social services reporting was often of limited value in evaluating the effectiveness of services.

5.31 Most ACPC members recognised the limitations of information available to them. Even the limited information they received was not being used to best effect. Comparative information to show, for example, the relative rates of registration of children on their child protection register compared with other areas was generally not made available. This meant that they were unable to reflect on their performance in the context of local and national trends. Such information would be of particular value to the ACPC in identifying objectives for their business plan.

A Culture of Challenge

5.32 In the areas where we judged the safeguarding arrangements were working well, we found that there were certain key characteristics. These included confident senior managers, who were accessible to other agencies, in regular communication with each other and highly committed to safeguarding children. There was mutual support and openness to debate and challenge. There was a culture locally that accepted the legitimacy and importance of robust debate and challenge between agencies, a willingness to listen to concerns, to engage with them and address issues.

5.33 Where services were under severe pressure because of staffing difficulties there was understanding, support and sympathy in most areas. Nevertheless, the underlying commitment to joint working was vulnerable. It was crucial that these services kept other agencies clearly informed and considered the impact it had on them.

5.34 In one area, we heard of a social services team writing out to inform other agencies that it could no longer respond to any but the highest priority work. This indirect communication was very badly received and seriously harmed inter-agency relationships.

5.35 Where relationships were already under strain, there was less sympathy towards services experiencing difficulties, and it was apparent that restoring trusting relationships presented a major

challenge. These strains arose from unresolved tensions over past serious case review findings, poor relationships between senior staff in the past and unresolved resource issues.

5.36 At the time of the children's safeguards inspection fieldwork, the National Health Service (NHS) and the organisation of local health services were going through a major reorganisation to encompass the modernisation agenda. This resulted in the dissolution of health authorities and the development of Primary Care Trusts (PCTs). Senior managers had either not yet been appointed or had not taken up their new posts. It was therefore understandable that they had yet to identify safeguarding of children as a priority. At the same time, this was a serious weakness within local agency arrangements, which needed urgent consideration.

5.37 Many services had been subjected to major reorganisation and this was having a significant impact at the local level:

- CAFCASS was formed in April 2001, had experienced major tensions throughout the first year of its existence, and had yet to establish policies and guidance to support working with ACPCs and other agencies;
- many police forces had experienced some reorganisation of their services that had impacted upon their specialist teams responsible for child protection work;
- the National Probation Service (NPS) had been established in April 2001, and was engaging with a major programme of change. This included the development of MAPPA;
- social services had been affected by local government reorganisation, the transfer of under-eights registration and inspection work to OFSTED, the creation of CAFCASS and the introduction of Youth Offending Teams. Most of the local councils had also reorganised their social services in response to these changes and the introduction of the *Framework for the Assessment of Children in Need and their Families* (20).

5.38 The scale of these changes had had a significant impact on inter-agency communication and the priority given to safeguarding children. Energy had been devoted to establishing the new organisations nationally and locally. With substantial changes amongst senior managers, relationships had to be re-formed and open communication and trust re-established. The ability of these new relationships to accept challenges in terms of their safeguarding arrangements had yet to be tested.

5.39 In some areas, we found defensive senior managers who found

challenge threatening. This resulted in less willingness to listen to the concerns of other agencies and engage with those concerns. This was to the detriment of good joint working and left crucial issues, such as concerns about thresholds for intervention, unresolved.

Audit and Evaluation

5.40 Most ACPCs were undertaking some file audits. This often focused upon reviewing files of social workers, but did not directly engage with the work of professionals in other agencies. This was a serious limitation. It meant that the work of other agencies was not being scrutinised, and perpetuated an inappropriate emphasis upon the work of one single agency.

5.41 The lessons from audit findings were not impacting positively upon practice. For example, in several areas we identified weaknesses in practice that were almost identical to concerns that had been identified and reported on in audit work. These included in one area a failure to respond adequately to long-standing situations of neglect of children by their parents. A case file audit over a year earlier had identified just this weakness, but the change to the local practice necessary to address this had not been achieved.

5.42 The resources to undertake audit work were limited. Those best equipped to evaluate the quality of practice were often exceedingly busy. They were senior practitioners in different agencies, who already were expected to serve on the ACPC or some of its sub-groups, without adequate recognition of the time required to do justice to this work in addition to their own agency workloads. Generally, ACPCs did not have access to specialist resources and skills to undertake audit work effectively.

Serious Case Reviews

5.43 The most frequently found form of review was through Chapter 8 serious case reviews. Some areas had established effective arrangements to conduct such reviews, but other areas struggled to establish them appropriately. This resulted in review reports of widely varying quality and length.

5.44 There was a strong tendency for review teams to make excessive numbers of recommendations that could limit their impact and utility. In one not untypical example, the review team concluded that they had not identified any significant weaknesses in practice that could or should have prevented the injury to the child, but still made over 50 recommendations of changes to practice. We considered that this would be counter-productive and few recommendations would be implemented.

5.45 In many areas, the time taken to complete Chapter 8 serious case reviews was excessive. In one area, a review took nearly three years to complete, and in several others they were taking over a year. ACPCs needed to make greater efforts to achieve the statutory guidance of four months for completion of these reviews.

5.46 The prosecution process may be an important issue within some of these cases and ACPCs need to secure the involvement of the CPS in the review and the consideration of the report in appropriate cases.

5.47 Two areas had not undertaken any Chapter 8 serious case reviews over the past three years. In one of these areas, we considered that one case should have been subject to a serious case review. For both areas, we concluded that they would have benefited from conducting reviews of one or more cases where there were concerns about practice; these would have provided a check on practice and a valuable learning opportunity.

Conclusions

5.48 The ACPC could be effective where there was strong leadership and it commanded the support and commitment of other agencies. This required confident senior managers in the different agencies who were committed to safeguarding children, had established effective communication with each other, and were open to challenge in respect of safeguarding arrangements.

5.49 This was rarely evident. In most areas, the ACPC was not exercising effective leadership, and other agencies did not accept any accountability to it. Not all appropriate agencies were represented on the ACPC, and in only one area was the Youth Offending Team represented. Representatives did not always have the seniority and authority to make decisions and commit their agencies.

5.50 Funding for the work of the ACPC was seriously inadequate in all but one area: ACPCs were not able to undertake sufficient audits of work, could not run effective campaigns to address safeguarding issues in local communities, or monitor safeguarding practice effectively. ACPC business plans were poorly developed and the use of information to inform the work of the ACPC was particularly weak.


5.51 Serious case reviews (Chapter 8 reviews) were not always being conducted when they should be, took too long to report in many cases, were not always made available to all agencies, and the monitoring of recommendations was not robust.

5.52 Many representatives of agencies on the ACPC felt that the difficulty in getting funding and support for the work of the ACPC would best be addressed if it became a statutory body: we recommend that consideration be given to this.

5.53 The Government's modernisation agenda had led to major changes for many organisations, and these were having a huge impact on services at the time of these inspections. Some senior executives and senior managers were new in post, and had not made safeguarding children a priority. Trust and communication between senior managers had been weakened, making it difficult to ensure openness and challenge between agencies in respect of safeguarding children.

5.54 Local arrangements in respect of potentially dangerous persons had not been developed consistently between areas. In the absence of detailed national policy and guidance, most had developed independently of local safeguarding arrangements.

5.55 Similar concerns to those raised about the status of the ACPC were voiced about the status of MAPPPs by some managers in respect of arrangements for the management of potentially dangerous persons. We recommend that consideration be given to establishing them on a statutory basis, and that there should be a national policy framework for MAPPA.



6 Responding to Children in Need of Safeguarding

Introduction

6.1 Social services have the lead responsibility for children about whom there are welfare concerns. Other agencies look to them for advice, support and guidance when they have concerns about the welfare of children. Social services set the threshold for undertaking inquiries and coordinate the assessment of need and risk of significant harm, working in partnership with other agencies, the child and parents and carers.

6.2 The responsibility of the local authority to make inquiries where there is concern that a child may be at risk of significant harm is set out in section 47 of the Children Act 1989 (4), and they are commonly known as section 47 inquiries.

6.3 Social services are also responsible for leading the planning of services for children and families to provide support to families under stress. We looked at how well local services are being developed and their contribution to safeguarding children.

6.4 In the past, when there have been public concerns about the apparent failures of agencies to safeguard children, inquiries have repeatedly identified the failure of all agencies to share information relevant to the welfare of the child. Accordingly, we looked with particular care at information sharing protocols and systems.

Findings

6.5 Social services are usually the first point of contact for agencies that have concerns about the welfare of a child. The quality of the initial response and the subsequent initial assessment is crucial, as it determines the whole course of work with that family.

6.6 Many staff in agencies in most authorities expressed concern about the accessibility and quality of this initial response by social services. Staff from these agencies were, quite appropriately, looking to social services to provide leadership and support in guiding the response to welfare concerns. They identified the need for easy access to consult with social services about the seriousness of symptoms and

Referring Child Welfare Concerns

behaviour that may be indicative of child abuse or neglect. They looked to social workers for support to help them in the fulfilling of their responsibilities related to the welfare of the child.

6.7 Staff felt that, in practice, this support was often lacking. Duty systems were found to be impersonal and unresponsive, and social services were operating tight criteria for accepting referrals and were often weak at offering advice and support to other agency staff.

6.8 Many social services departments were experiencing serious staffing difficulties. Too often, the response was to deploy the least experienced, non-permanent members of staff on the teams responsible for duty and initial assessment work. This was creating severe tensions, as it was to these staff that other agencies looked for expert advice and support. In some instances, the responses of staff from other agencies to this experience of unsatisfactory responses to their concerns were either to try and contact a social worker they knew from previous work experience or to stop looking to social services for support and deal with issues independently.

6.9 Serious concerns were expressed in a few areas. Teaching staff in one area said that they no longer reported concerns, as they had lost confidence that social workers would respond positively. Police in another area reported a loss of confidence in the response of social services.

Thresholds for Responding to Child Welfare Concerns

6.10 The level at which social services operated its thresholds for responding to child welfare concerns was a major concern in almost all the areas. The view was strongly held that social services were only responding to the highest levels of child welfare concerns where evidence of abuse or neglect was very apparent. Lower level concerns that other agencies felt warranted follow-up were too often not accepted for a response or a service by social services.

6.11 This often left other agencies feeling responsible for working with situations that they considered posed high risks of harm to children's welfare, without the support of social services.

6.12 Previous inspections have found serious concerns about the initial responses to child welfare concerns. The Social Services Inspectorate (SSI) report *Developing Quality to Protect Children* (39) concluded that some duty arrangements were inherently unsafe as there was no ownership or sense of responsibility for referrals and duty cases, and assessments became delayed. They stated that referrals must be positively managed, and decisions actively made on whether a referral is accepted, and how it is responded to, within a day of receipt. They found tactics of delay, such as sending out standard

letters inviting people to the office, were not acceptable. Experience clearly indicated that people were very unlikely to respond, and this procedure shifted responsibility to those least able to exercise it.

6.13 *Clinical Governance Reviews of NHS Trusts* by the Commission for Health Improvement (CHI) (44) have identified a number of shortfalls in the practice of individual hospitals. This inspection has identified:

- some Accident and Emergency (A&E) departments did not have access to a full set of child protection procedures, with a consequent lack of awareness of procedures and responsibilities;
- poor identification of children at risk of harm in some A&E departments;
- lack of dedicated children's facilities in some A&E departments;
- lack of 'named' doctors or paediatricians with child protection responsibilities, and inadequate time allocated to the role;
- varying levels of trained children's nurses in A&E departments, in particular;
- not all A&E departments had access to the electronic child protection register, and reported difficulties in contacting social services out of hours;
- some 'designated doctor' positions, with child protection responsibilities, being held vacant for prolonged periods;
- insufficient awareness by all health care staff of the 'designated doctor' role or who should be the most appropriate person to hold that position;
- child protection practice not being routinely audited;
- variable access to a paediatric liaison health visitor within A&E departments;
- need for more specialist doctors and nurses for looked after children within NHS organisations.

6.14 Threshold issues could be addressed most effectively through regular multi-agency workshops and training, where case scenarios were discussed between professionals from a range of agencies. Where this was regularly taking place, concerns about thresholds were much less prominent.

6.15 Most agencies, including social workers, considered that there were inadequate services to support families under stress. At the same time, social services were under pressure due to the high number of

referrals they were receiving. This created tensions for other agencies, who found that if they could establish that the family posed substantial risks to the welfare of the children, this often increased the chance of accessing services for that family.

6.16 Other agencies also reported that the response of social services to child welfare concerns operated with too strong a distinction between children perceived to be at risk of significant harm, and other children deemed only to be in need. For children considered to be at risk of significant harm, the response of the majority of social services assessment focused almost exclusively on an assessment of risk of harm, and social workers failed to consider the wider needs of the child within their family.

6.17 Evidence from file reading during this inspection identified that the factors associated with the different ethnic backgrounds and cultures were not given sufficient weight in assessments. We concluded that diversity issues were not sufficiently integrated into day-to-day practice. Social workers and staff from other agencies found it difficult to undertake assessments of children and families where there was evidence of risk of significant harm within the broader framework of need in a holistic way that adequately addressed issues of ethnicity and culture. Significantly, religion was rarely recorded or considered in any social services files.

6.18 The concerns about thresholds go further. We were told on many occasions that the police were not routinely being consulted about potential section 47 inquiries by social services, and clearly evidenced that this was the case in one authority. We were informed that social services were often reluctant to undertake section 47 inquiries, and that in cases where they did, they were often reluctant to convene child protection conferences. The process for determining if an initial child protection conference should be convened needs to be open and inclusive of relevant agencies who have contributed to the section 47 inquiry. This clearly was not always the case.

Assessments

6.19 *The Framework for the Assessment of Children in Need and their Families* (20) is formal guidance to local authorities issued under section 7 of the Local Authority Social Services Act 1970. It was developed to support implementation of *Working Together to Safeguard Children* (3), as complementary guidance to ensure that there is a comprehensive assessment of need for children where there are welfare concerns. In most areas, social services, working with the ACPC, had planned training for staff from relevant agencies on the implementation of the Assessment Framework.

6.20 The effectiveness of training for staff from all agencies primarily involved in responding to child welfare concerns and contributing to assessments of need varied. In some areas, very positive efforts had been made to engage staff from agencies other than social services. In several areas, this had included forming teams of trainers drawn from practitioners across agencies and this could work very well.

6.21 Implementation of the Assessment Framework had proved demanding in all areas, and in some areas staff had not been trained in time to support implementation from April 2001. In one area, plans to cascade the training through a team of social workers had not materialised due to staffing difficulties within some parts of the authority. In most areas it had proved difficult to sufficiently engage staff from other agencies. In one area, an imaginative approach had included offering training outside of normal office hours – early evenings or Saturday mornings – for staff from other agencies.

6.22 The impact of this training was also varied:

- it was apparent that most social services were making great efforts to complete initial assessments within seven days;
- almost all social services were struggling with the completion of the core assessments at all, let alone within 35 days;
- health agencies had completed training on the Assessment Framework in most areas and had actively contributed to the ACPC training initiatives;
- staff from other agencies often had minimal training in or understanding of the Assessment Framework;
- few agencies (other than social services) understood how they should participate in the Assessment Framework.

6.23 The links between the assessments conducted under the Assessment Framework and those undertaken by other agencies were almost non-existent. Other agencies' assessments, particularly those involved in assessing adults who present a risk of significant harm to children, were undertaken completely separately.

6.24 It was unclear what longer-term vision of use of the Assessment Framework was behind the implementation plans. It was not clear how other agencies were expected in the longer term to contribute to the assessment process, what referral forms they were expected to use, or how they contributed to the Assessment Framework.

GOOD PRACTICE

In Stockport and Nottingham, health visitors had been well trained to use the Assessment Framework, and social services would accept their assessment to access some preventative services.

Inquiries and Investigations into Child Welfare Concerns

6.25 Overall, the quality of core assessments for children considered at risk of significant harm was disappointing. Too few assessments demonstrated an engagement with the social history of the family, a reflection on the evidence, synthesis and analysis, and a concluding assessment of need and risk of significant harm. They did not provide an adequate foundation for planning intervention and work with the family.

6.26 Social services have the responsibility for undertaking the inquiries when there is evidence that a child may be at risk of significant harm, under section 47 of the Children Act 1989 (4). The police have the responsibility for investigations in respect of criminal activity.

6.27 There were very good working relationships between social workers and police officers in responding to children considered at risk of significant harm where there was clear evidence of the need for a police investigation of a potential crime.

6.28 In investigations where a video interview was undertaken, it was accepted by both agencies that in almost all cases the police officers would lead the interview, with social workers providing a supporting role. We considered this appropriate, as police officers have acquired greater experience of this work, and are trained to elicit evidence that will withstand legal scrutiny.

6.29 Where the police were not from the specialist teams, there was greater concern about the quality of video interview evidence. Both social services and the Crown Prosecution Service (CPS) noted this. It reflected the fact that many of these officers were not experienced in this work.

6.30 There was a serious lack of knowledge about police powers of protection amongst uniformed police officers. This was also the case with some social workers, and one ACPC's child protection procedures demonstrated a misunderstanding of these police powers. Police in most areas were concerned that social services too frequently requested that the police use their powers of protection inappropriately, when they should have sought an emergency protection order through the courts. They also complained that social

Safeguarding Children on the Child Protection Register

services were very slow to respond when the police did exercise their powers of protection.

6.31 *SSI Children's Services Inspections* (39 and 40) identified delays in intervening decisively to safeguard children in some families where there were long-standing concerns about the adequacy of parenting. Children in families where carers had a history of alcohol and substance misuse, mental illness or learning disabilities were particularly vulnerable. The absence of chronologies and summaries and in some cases a failure to thoroughly review past work with these families were all factors that led to drift. The consequence for some children was delay in admission to being looked after, and when they were admitted, they had more complex histories of abuse and emotional harm that might have been addressed more effectively earlier.

6.32 Children whose names had been placed on the child protection register were receiving a priority service. This was justified. The guidance requires that core groups are established for these children, to coordinate services between agencies, and these were generally established and ensuring that children were monitored and services were working together. In some areas, there was need for further local guidance in respect of the role and responsibilities of core groups to ensure that they always were established and undertook their role effectively.

6.33 Information sharing was much better for children whose names were on the register. These children were the subject of agreed plans, and the progress of these plans was regularly reviewed. Review child protection conferences were in the vast majority of cases being held at the frequency required by guidance.

6.34 *SSI Children's Services Inspections* (40) have found that there have been significant numbers of children on the child protection register who did not have an allocated social worker. It was good to find that this was not the case in any council visited during the children's safeguards inspections; all children on the child protection register had an allocated social worker.

6.35 The vast majority of children whose names were on the register were well safeguarded: that has also been the finding of the *SSI Children's Services Inspections* (39 and 40).

6.36 There were concerns about how different agencies access the child protection register, and when they should do so. Practice varied, and this reflected a lack of clarity about the purpose and use of the child protection register. We recommend that the purpose and use of

The Role of Specialist Teams

the register should be reviewed. Checking the child protection register should not substitute for checking the social services client index to see if a child is known and if there are concerns about a child. There should also be systems to identify if repeated enquiries are being made in respect of a particular child or family, so that early warnings of potential risk of harm can be responded to.

6.37 *SSI Inspections of Children's Social Services* (40) have found that there was evidence of a better initial response to referrals if this was undertaken by a dedicated duty and initial assessment team.

6.38 Examples of positive approaches by social services dedicated teams included:

- inter-agency protocols and direct referrals between agencies;
- social services created referral forms for use by other agencies, that ensured pertinent information was included;
- valuable contributions from health visitors and teachers to the assessment;
- protocols between the police and social services on domestic violence referrals;
- monitoring of times for responding to referrals.

6.39 In many police areas, the specialist child protection units only dealt with abuse against children by members of the family and relatives, and did not deal with stranger abuse. This meant that non-specialist officers dealt with investigations into allegations of abuse by strangers, and the quality of work was significantly weaker. We considered this a serious matter and recommend all forces should reconsider the remits of their specialist units responding to child welfare concerns.

6.40 A wider remit for a unit also supported better links between domestic violence, child sexual exploitation and other child welfare concerns. This led to a more consistent and better coordinated response.

GOOD PRACTICE

Surrey and Kent police have both introduced vulnerable person units to deal with responses in relation to child protection, vulnerable adults, domestic violence and sex offenders.

6.41 The Crown Prosecution Service (CPS) expressed concern about the quality of video interview evidence in most areas. Some areas had initiated audits of the quality of these interviews. There was rarely sufficient regular refresher training for staff undertaking these interviews and the CPS was often not involved in this training.

6.42 There were specific concerns as to how NHS Direct services linked into local ACPC child protection procedures. It was not always clear how information about child welfare concerns was shared with users of services or referred to local services. We considered that NHS Direct staff require further training on information sharing.

Preventative Services

6.43 Staff from all agencies knew how important it was to intervene early to provide support to families under stress, to prevent problems escalating to place children at risk of harm.

6.44 We noted a range of services in different areas that were very positive:

- schemes to ensure attendance at school, including truancy sweeps;
- police attendance at schools, which improved attitudes towards police and enabled a quicker response to incidents;
- local education authorities working with schools to reduce the incidence of exclusion;
- the development of alternative education provision for children who struggle in mainstream settings;
- drop-in centres for teenagers, providing sexual health advice and contraception, and outreach services that were very young people orientated;
- police community safety initiatives that focused upon preventing offending;
- health professionals work with families in an army garrison.

GOOD PRACTICE

Nottingham City had introduced truancy sweeps, supported by preparation at schools so that children returned to school were welcomed back and encouraged to rejoin lessons.

The police in Nottingham City had introduced restorative conferencing which had avoided exclusions from schools for 96 out of 100 children conferenced.

Shropshire had an outreach worker to support young people accessing health services, including the Genito-Urinary Medicine (GUM) clinic.

In North Yorkshire, paediatricians, GPs, health visitors and school nurses were providing good support to families through an NHS clinic in an army garrison.

6.45 In all areas, staff were concerned at the limited resources to provide support to families under stress. There were difficulties of accessibility of services and the range available. In some county areas, where expenditure by the local authority on children's services was comparatively very low, there was an acute shortage of services to support families under stress.

6.46 Serious concern was expressed in almost all areas about the shortage of Child and Adolescent Mental Health Services (CAMHS). These often had long waiting lists, and social services reported difficulty in accessing services either for advice for social workers or to refer children and their families for assessment. Some were experiencing difficulty in recruiting staff. Many were short of resources. Some adult mental health services experienced difficulty in information sharing with CAMHS health services and other agencies.

GOOD PRACTICE

In Hammersmith and Fulham, a consultant paediatrician had been appointed as a link specialist between two acute hospitals. His functions included ensuring information was appropriately shared about vulnerable children and to chair regular multi-disciplinary meetings about children where there were welfare concerns.

Information Sharing in Respect of Vulnerable Children

6.47 The *HMIC Thematic Inspection of Child Protection* (42) identified concerns at the reluctance of some agencies to pass on information about suspicions of possible child abuse or children thought to be at risk of harm. Social workers, probation officers and prison staff were found to be comfortable with passing on information, but teachers, medical staff and youth workers often felt inhibited by their understanding of confidentiality, a lack of clarity of expectations and fears of jeopardising relationships with parents or young people. They recommended that clear protocols for the sharing of information and making referrals be drawn up with each agency.

6.48 In the children's safeguards fieldwork, staff from all agencies reported that they were confused and unclear about responsibilities and duties in respect of confidentiality and information sharing in respect of child welfare concerns. Staff were often unclear themselves, and many staff from all agencies expressed concern about the openness of other agencies to sharing information.

6.49 There were a number of specific and often repeated concerns:

- information about original offences was not easily available to police officers planning for responses to the release of offenders;
- some schools were seen as reluctant to share information and in the case of some independent schools, to engage with local child protection procedures and key agencies;
- some adult psychiatry services were perceived as reluctant to share relevant information with other health services and other agencies.

6.50 There were also specific concerns around court services:

- some children's guardians in certain areas appeared to be prohibited from sharing information with local authorities about child protection concerns that came to their attention during the course of their enquiries without obtaining prior leave of the court, which was not always granted;
- there was a lack of agreement about information sharing when court cases transferred from the civil to the criminal courts;
- there were specific concerns about access by the police to third-party information relevant to the investigation of criminal offences and in subsequent court proceedings, and its subsequent revelation to the CPS and its disclosure to the defence.

6.51 The introduction of recent legislation, including the Data Protection Act 1998 (45) and the Human Rights Act 1998 (46), have not been supported with training that has been understood by many staff working with children and families. On the contrary, it has increased uncertainty and confusion for many staff.

6.52 In most areas, the ACPC had not initiated, supported or endorsed joint information sharing protocols between agencies. At the time of the inspection, some areas were working on draft protocols, but most staff did not know about these. There is confusion nationally about some information sharing issues and some are still to be tested out in case law. Some ACPCs were looking to guidance to be issued on a national basis on these issues, and the CPS, ACPO and social services are working to agree a national protocol for third-party disclosure.

6.53 There were formal information sharing protocols between the police and probation service in respect of offenders who pose a risk of harm to the public, including children, in all areas inspected. In most areas, other agencies, including social services, YOTs, health services and housing had also signed up to these protocols.

Information Sharing in Respect of Potentially Dangerous Persons

GOOD PRACTICE

In Harrow, a draft referral form for the MAPPPs included a summary of relevant legislation.

Kent police had made full use of the Memorandum of Understanding between the police and prison services by establishing a well-developed network of police/prison liaison officers.

6.54 The development of the Violent and Sex Offenders Register (ViSOR), a national database, was seen as having the potential to support both police and probation staff in managing offenders more effectively.

Conclusions

6.55 There were good working relationships between staff in most key agencies. Specialist police officers in child protection teams worked particularly well with social workers on investigations into child welfare concerns, and with specialist child abuse prosecutors where prosecutions ensued.

6.56 When child protection inquiries were undertaken with police who were not part of specialist teams, the quality was much less satisfactory, and the response to abuse of children by non-relatives by many police forces was not good.

6.57 There were serious concerns expressed in most areas by professionals who considered that social services were operating thresholds for responding to child welfare concerns at all stages of the process that were too high. These concerns needed to be addressed by social services.

6.58 Similarly, staff from other agencies were very frustrated that they found it very difficult, if not impossible, to contact skilled experienced social workers with whom they could discuss welfare concerns, or even make referrals in some areas. In too many social services, the initial response systems were experienced as bureaucratic, and were not staffed by skilled, experienced permanent staff in sufficient numbers. Arrangements by social services for responding to child welfare concerns and referrals needed strengthening in most areas, and greater priority needed to be given to providing advice and support to other professional colleagues.

6.59 Work had been undertaken to train staff from most agencies on the Assessment Framework, but there remained a lot to be done.

Staff from other agencies were not always clear about the documentation to use or how to contribute to the Assessment Framework. It had yet to become established as a positive support to staff across agencies.

6.60 The quality of assessments needed to be developed. There was too great a distinction in the assessment work in respect of children considered to be in need, and those considered to be at risk of significant harm. For those considered to be at risk of significant harm, the focus was often too narrowly on the child and her/his immediate environment, and insufficient attention was given to the wider family context or the past social history. Assessments frequently did not have sufficient synthesis and analysis of data to support decision-making and forming child protection plans.

6.61 Communication between staff of all agencies could be improved. There was confusion about the implications of the Data Protection Act 1998 and Human Rights Act 1998, and suspicion between staff from different agencies, who did not always understand each other's roles and responsibilities. This needs addressing by government departments and at a local level.

6.62 There were particular concerns about how NHS Direct and NHS walk-in centres linked to local child protection arrangements, and how they explained to users that child welfare concerns were shared with other agencies.

6.63 In many areas, the services to support families under stress were quite inadequate. This was true both of individual agency services and joint services. This meant many families where safeguarding issues did not warrant registration were often not receiving services that might prevent them becoming of increasing concern to services. There was a need to strengthen local joint planning arrangements.

6.64 Where children were placed on the child protection register, they received priority for services, and these services were generally well coordinated and supported protection plans robustly.

6.65 There was confusion over arrangements for access to the register and how it should be used. We recommend that there should be reconsideration of the purpose and use of the child protection register.



7 Involving Children and Young People and Making Them Central to Safeguarding

Introduction

7.1 We know that services are better able to meet the needs of children and young people when they engage with them directly. When services listen to their concerns, learn from their experience and consult young people about specific matters, services become more responsive and better used by children and young people.

7.2 We wanted to see how well services were engaging with children, young people and their families and carers.

7.3 We also focused upon specific groups of children and young people who are known to be at risk of harm and whose needs have not been adequately addressed by services in the past. These included those where there is domestic violence in the family, young people abused through sexual exploitation and prostitution, and those who go missing.

7.4 During the inspection process, other groups whose needs were not being adequately addressed were brought to our attention.

Findings

7.5 All agencies recognise that they have much to learn in listening to the views and experiences of people, including children and young people, who use their services, often involuntarily.

7.6 All local authorities had taken steps in recent years to engage with the experiences and views of young people who have been in their care. We found many examples of projects and initiatives to engage with these young people, and to learn from their experiences.

7.7 The examples seen in relation to the educational experiences of children and young people in care reflected the general improvements noted in OFSTED's report of 2001, *Raising the Attainment of Children in Public Care* (28). However, it was sometimes not clear that these projects and initiatives were influencing policy and practice more generally in the area.

How Well Were Children Involved in Services

GOOD PRACTICE

In Hammersmith and Fulham, a steering group of young users in one area had helped determine the venue for a drop-in family planning and drug misuse service.

In North Yorkshire, the LEA had taken full cognisance of the new Code of Practice for pupils with special educational needs. They ensured that all pupils with Statements of Special Educational Needs contributed to their reviews. Pupils placed out of county in residential special schools were given planned time to represent their views to a LEA representative.

7.8 Other agencies had done less to develop mechanisms to capture the feedback from young service users, and all recognised they needed to do more.

7.9 Most agencies recognised the need to ensure that services were child-orientated.

7.10 Most Accident and Emergency (A&E) departments in hospitals had dedicated areas for children and young people, to ensure they received an appropriate service from trained children's staff.

GOOD PRACTICE

Stockport NHS Trust have recently built a new children's unit, the Tree House. They had consulted with children and their families about the design, and ensured the whole service was very child-orientated.

7.11 The Social Services Inspectorate (SSI) report *Excellence Not Excuses* (47) identified that families from minority ethnic communities seeking support often experienced difficulties in accessing services because they did not understand the role of social services. This was particularly an issue if English was not their first language. Although councils had translation and interpretation services, few had addressed the issue of dealing with immediate needs for interpretation for people who presented in reception or duty rooms.

7.12 The same report identified that assessments of families from minority communities were often partial, and they rarely covered the child's needs, parenting capacity and environmental issues. In some instances the inspections found that the safety of ethnic minority children had been compromised because physical and sexual abuse had not been identified properly and dealt with as a child protection issue.

Making Services Responsive to Children

7.13 An inter-agency group had initiated the use of two questionnaires at the conclusion of Crown Court cases, to obtain information from child witnesses and their carers about their experiences of the court process. This information was used to inform strategic planning. In addition, the information was analysed by police and feedback given through the Trials Issues sub-group on Victims and Witnesses. The CPS used this information as a de-briefing tool in order to learn lessons at the end of prosecutions.

7.14 In one case involving a young victim of rape, who was a member of a minority ethnic group, the victim was asked if she wanted a female prosecuting barrister of the same minority ethnic background and the victim's views were also sought on the method of giving evidence. In the past, this has not always been routinely done with children, but in future child witnesses will always be considered as vulnerable, and therefore potentially eligible for the implementation of the special measures contained in Part 2 of the Youth Justice and Criminal Evidence Act 1999 to enable vulnerable or intimidated witnesses to give their best evidence in a criminal trial. Practice guidance was issued by the CPS in January 2002, and a framework for a local protocol between police and the CPS has been developed in consultation between the CPS and ACPO.

GOOD PRACTICE

In North Yorkshire, an inter-agency group initiated the use of questionnaires at the conclusion of Crown Court cases, to obtain information from child witnesses and their carers about their experiences of the court process. These were used by the CPS as a de-briefing tool.

In Nottingham City, the CPS sought the views of child victims on the method of giving evidence.

7.15 Kent Council had established a very effective service to address the needs of the high numbers of unaccompanied asylum-seeking children and young people entering the county. This ensured that they were safeguarded and had access to advocacy services and complaints systems.

7.16 The 1998 SSI report *Removing the Barriers for Disabled Children* (48) identified that social work assessment of disabled children and their families was often focused on the need to support the parents rather than on the child's welfare. On occasions this led to child protection concerns and the importance of choice for children not being recognised. The report also identified that some specialist staff were ill-informed about child protection issues. The situation for black children with disabilities is compounded by there

being little provision for their various needs (47). The safeguards inspection did not specifically focus on safeguarding children with disabilities and this is therefore worthy of further investigation.

GOOD PRACTICE

Nottingham had established some positive joint schemes for children and young people with disabilities.

In Hammersmith and Fulham, an acute hospital had established a good transition service for young people with disabilities into adult services.

Planning Services for Children and Young People Deemed in Need of Protection

7.17 We found that it was increasingly common for young people and children to be invited to the initial child protection conference, but in practice few attended. In contrast, most parents attended, even when they were the perpetrators. There is a tension here that several staff commented upon; the perpetrator can be given priority over the abused child in the conference setting.

7.18 The presence at initial child protection conferences of parents who have abused their children, and who may be hostile to the child protection service, causes concern to some staff. Many staff at the conference will continue to have regular direct contact with the parents through their professional role, and this can make them reluctant to share the extent of their concerns about the parents. In too many cases, the focus is overmuch upon reports of recent discussions with the parents, and does not capture the extent of longer-standing concerns. Some staff acknowledged that they were reluctant, and at times unwilling, to voice their opinions of the parenting capacity of aggressive parents.

7.19 Most social services now have staff dedicated to the welfare of children looked after: children's rights officers or advocacy services, etc. These were less available for children on the child protection register.

7.20 There were some innovative services for pregnant girls of school age and those who have babies, and supportive parenting schemes.

GOOD PRACTICE

In Kent, the role of midwives had been reviewed to ensure their contribution to identifying welfare concerns was fully utilised.

Stockport and Surrey health visitors had developed specific first parent support schemes.

Safeguarding Children Living Away from Home

7.21 Services for children in public care are probably subject to greater regulation than any other social service. There is an expectation of rigorous checks being undertaken by council staff, registration and inspection units (up until April 2002) and, more recently, the National Care Standards Commission. The SSI report *Someone Else's Children* (18), published in 1998, identified that while social services were well aware of their responsibilities in this area they had at that time not developed effective monitoring of compliance with procedures and expectations. Subsequent inspections of children's services by the SSI (39 and 40) have included a focus on ensuring that children looked after are being properly safeguarded. Emphasis has been made on ensuring that complaints procedures are user-friendly, that social workers undertake statutory visits and reviews are undertaken regularly.

7.22 Effective systems and processes for care planning and reviews are important to ensure that children looked after are being well cared for and are safe in their placement, and also enable children, parents and carers to raise any concerns. Performance was variable within councils: up-to-date care plans and reviews were evidenced in about 85 per cent of relevant case records. While the vast majority of children, parents and carers interviewed or surveyed reported that they were invited to reviews, and most attended them, a number of service users reported difficulties in making their views known in such meetings, finding them uncomfortable and intimidating. Practice was variable across councils in relation to the efforts and mechanisms used to enable children and parents to participate effectively in these processes.

7.23 Inspections (39, 40 and 41) identified that young people in residential and foster care were often unhappy about the lack of contact from their social worker, particularly those in out-of-authority placements. Some councils were not meeting the minimum requirements for visits by social workers of children looked after. Many councils have, however, set up independent visitor and advocate schemes, and one council had arranged for an independent visitor to undertake monthly 'well-being' interviews with each child in residential care.

7.24 SSI children's services inspections also examine council's practice and performance in relation to the undertaking of independent and unannounced monthly monitoring visits to each of their children's homes. Interviews are conducted with children's rights officers and an examination of practices in relation to the availability of independent advocates and advice is undertaken. While practice in all these areas has been improving over the years there remains a lack

of consistency. Shortcomings are brought to the attention of senior managers and councillors and included in published local reports.

7.25 SSI inspections of social services residential secure accommodation include a detailed examination of the child protection and safeguarding procedures operating within each establishment. This includes care planning and reviewing processes, children's access to complaints procedures and independent advocates, the operation and monitoring of all forms of control and restraint of young people, anti-bullying policies, staff guidance, training and support, and whistle-blowing procedures. Inspections include discussions with residents and staff and observation of practice.

7.26 Any deficits or concerns are brought to the attention of senior managers and are contained in published reports. While individual deficits have been identified within some establishments, overall there have been good standards of care and protection of children and young people placed within council secure accommodation.

7.27 Regular inspections of residential independent schools by OFSTED include coverage of children's welfare and they have identified inconsistency in the approach taken by schools to promoting the welfare of children and safeguarding children.

7.28 Variations in practice have also been found in foster placements (36), with deficits in the quality of supervision given to carers and the quality of visits by social workers, care planning and annual reviews.

7.29 The inspection by the SSI of arrangements for supporting and supervising privately arranged foster placements (49) also identified some areas of concern. The inspections found that most private foster carers were unaware of the requirement to register with social services. Many had been caring for children or young people for some time before coming to the attention of social services. The inspection identified the potential key role of professionals in education and health services. They are likely to have contact with these children and can make sure that their situation is brought to the attention of social services in order to ensure that safeguarding measures are in place.

7.30 One of the priorities of Quality Protects (19) is improving the health care of children looked after, and ensuring that all children looked after receive regular health assessments. There were differing arrangements for carrying out health assessments for children looked after in different areas. In many areas, there was an identified lead paediatrician or doctor for children looked after, although she/he did

not necessarily carry out the health assessments: they were undertaken by a range of different medical practitioners. It was recognised as being a specialist area of work in some areas, and the preference was to have a specialist paediatrician to address the health care needs of children looked after. In one area, there were no arrangements for providing specialist paediatric input for children looked after.

GOOD PRACTICE

In Nottingham City, a comprehensive initial medical assessment was undertaken and a healthcare plan was produced for each child looked after by a Senior Nurse and a Community Paediatrician, both of whom were dedicated specialists in this work.

Complaints

7.31 *SSI Inspections of Children's Social Services* (40 and 41) have found that young people still experience serious barriers to making complaints about services. They have also identified a number of strategies that help young people to raise concerns or make complaints.

7.32 *The Commission for Health Improvement (CHI)* investigation into issues arising from the case of a GP convicted for sexual assault on five patients (50) identified concerns about the difficulties that patients have in making complaints. This is reminiscent of past inquiries into abuse in children's homes. One of the key findings of the CHI investigation was that there was an NHS culture that did not listen to or treat complaints inquisitively. Patients who tried to raise their concerns were left powerless in their discussions with professionals and managers. The NHS complaints system failed to detect issues of professional misconduct or criminal activity.

7.33 Since then, the *Kennedy Inquiry into the child heart surgery service at Bristol Royal Infirmary* (51) has identified similar concerns in respect of those patients. They expressed very serious concerns about the culture within that service for children. In both of these reports, the difficulties whistle-blowers experience were documented.

GOOD PRACTICE

A number of councils have involved young people in innovative ways to make it easier for them to register concerns and make complaints:

- young people being involved in producing the procedures and publicity;
- involvement of children's rights workers in the process and including an advocacy role.

Allegations

7.34 All services took allegations against staff seriously, and arranged for their investigation by someone independent from that service. The approach was generally robust, but we found weaknesses in the way allegations were recorded and in the final stages of decision making and resolution of the issues.

GOOD PRACTICE

Some authorities had established a special panel to address all allegations and ensure that there was clarity about child protection issues, investigations of allegations and disciplinary procedures.

Domestic Violence

7.35 We found active local domestic violence forums in all except one area, and that the level of awareness of the seriousness of the impact of domestic violence upon children was high. However, different agencies did not have a shared understanding of how domestic violence referrals were responded to. In some areas, referrals to social services were not being followed up, although the police thought they were.

GOOD PRACTICE

In Shropshire, the local police routinely followed up domestic violence incidents with one or more visits to the home over the next month.

In North Yorkshire a small local initiative called 'Patchwork' was undertaken to raise awareness in schools about the impact of domestic violence on pupils' educational and personal development. A series of drama workshops enabled pupils to recognise the issues involved. They learnt to deal more positively with domestic violence, be aware of how to help keep themselves and friends safe and the appropriate course of action to get help.

7.36 The sharing of information in relation to children living in situations where incidents of domestic violence had taken place was improved where the domestic violence liaison officers worked with the child protection teams.

Child Sexual Exploitation

7.37 We found a few good examples of local research being undertaken to identify the extent of the problems of sexual exploitation of children and young people, but this was the exception, and in most areas this had not been done.

GOOD PRACTICE

Nottingham City had done excellent work on researching the extent of child sexual exploitation and involvement of young people in prostitution, and as a result had developed an excellent range of services to meet their needs.

In Kent, the probation service had undertaken research to identify the extent of paedophile activity in one area.

7.38 In contrast, in the majority of areas we were told that there was no problem of children and young people of school age abused through prostitution, and that the problems occurred in other areas, but not in theirs. We considered this was a denial of the problem: it was apparent that little effort had been made to identify the extent of the problem or address the needs of these victims of child sexual exploitation. Some areas were beginning to address this at the time of the inspection.

7.39 In some areas, agencies recognised that work to address the needs of children subject to sexual exploitation had not been an ACPC priority, and needed to be. There has been recent guidance on the issues both as part of *Working Together to Safeguard Children* (3, 21 and 23) and from the Association of Chief Police Officers (ACPO) (52). Both highlight the importance of adopting a multi-agency approach through an agreed strategy. This needs to ensure the collation of evidence, co-ordination of intelligence information and development of protocols to ensure that effective monitoring takes place. For example, information about children going missing from specific children's homes was not being captured to identify that there were particular problems at some homes that warranted investigation.

Conclusions

7.40 There were many good initiatives which involved consulting with young people and seeking their views. At the same time, all agencies recognised they could, and should, do more to involve young people in services and their development.

7.41 There was a range of initiatives specifically to address the needs of service users from ethnic minority groups. Social services were the strongest agency in this work, whereas some other professional staff struggled with diversity issues. The integration of diversity issues into assessments of risk remained a difficulty for some social workers.

7.42 Young people and children were invited to attend key meetings about their futures, and there were services to support them in expressing their views. However, they rarely attended child protection conferences. In contrast, the parent who may be a perpetrator normally attended and could inhibit the contributions of some attendees.

7.43 The inspections identified groups of young people who present particular challenges to services that safeguard children. They include:

- unaccompanied asylum seekers;
- children with special needs in residential independent schools;
- children of travellers' families;
- children who change address frequently;
- children looked after placed outside their home local authority area;
- children with disabilities.

7.44 We recommend that particular attention be given to them in future inspection work.

7.45 There have been major concerns about the safeguarding of children in residential care in the past few years. It is important that inspection work continues to focus upon them and their safeguarding, and we recommend that this should continue to be a priority.

7.46 In most areas, there were active domestic violence forums that had raised the profile of the impact of domestic violence upon children. However, these forums were poorly linked into the work of the ACPC.

7.47 Very few areas had investigated the extent of sexual exploitation of children and young people, and many agencies denied that child prostitution was a problem in their areas. This was a denial of a serious issue that ACPCs in most areas needed to address.

7.48 Children and young people still find it hard to make complaints about services. Where allegations were made, these were taken seriously and investigated thoroughly. Support to potential and actual whistle-blowers was in need of strengthening.



8 Young People who Commit Offences

Responding to the Welfare Concerns of Young People who Commit Offences

Introduction

8.1 We identified the safeguarding of young people in Young Offender Institutions (YOIs) as a major concern. Previous inspections have highlighted the very serious nature of the risks many young people face in these institutions and the extent of self-harming behaviour. This contrasts with the reported good quality of care and protection of young people, including young offenders placed in secure accommodation provided by social services (see Chapter 7).

8.2 At the time of this inspection, there were no arrangements in place for the inspection of the Youth Justice Service (YJS) or the Youth Offending Teams (YOTs). This constrained what we could accomplish. We arranged for HMI Prisons inspectors to read YOT files in six areas, and we visited three YOIs. We also explored the links between YOTs, YOIs and Area Child Protection Committees (ACPCs).

Findings

8.3 We found the welfare needs of young people who commit offences were not being adequately addressed by those services responsible for their welfare. There were no national minimum standards for the work of YOTs, and there was no regular inspection of their work. They were operating largely in isolation from other services in most areas.

8.4 *Her Majesty's Inspector of Prisons* (HMI Prisons) has over recent years regularly reported in the strongest terms about conditions within YOIs. *The Inspectorate Annual Report for 1999-2000* (53) described the very serious levels of bullying taking place amongst young people in YOIs, and concluded that the emphasis of child protection procedures in YOIs should be on protecting young people from bullying. It is primarily bullying that leads many young people to consider and attempt suicide within these institutions.

8.5 Some of the findings about the young people detained in YOIs (54) illustrate the level of vulnerability:

- nearly 50 per cent of the children in YOIs have been, or still are, in local authority care, but many have lost contact with social services;
- most children in YOIs have a very fractured education experience and very significant learning needs and problems;
- many children have immense family difficulties; and
- many young people are discharged without anywhere to live.

8.6 An analysis of surveys undertaken of young people in YOIs (54) revealed that 24 per cent reported incidents of assault by other young people, 14 per cent reported they felt unsafe some of the time, and six per cent felt unsafe often. These figures confirm the findings of the Chief Inspector of Prisons that there were very serious levels of bullying and assault in many of these institutions, and in one establishment the regime was such that fears for safety and of bullying put most of the population of young people at risk of harm. In one YOI, there were over 700 reported incidents of injuries to young people over an eight-month period.

8.7 The 1999-2000 Annual Report (53) also identified the most serious concerns about the welfare of girls and young women aged 15 to 18 years held in custody. There is no specialist provision for them, resulting in their being held in adult prisons alongside adult prisoners. Some younger girls were placed in the antenatal unit, not because they were pregnant but because there was nowhere else to place them. Within the same unit there were psychiatrically disturbed and psychotic women who also were not pregnant.

8.8 Yet we found that there were very few referrals under the local child protection procedures being made to social services within the areas we inspected, and could not be confident of the response to safeguard these young people.

Working with Young Offender Institutions

8.9 In contrast to the provision of council secure accommodation, the principles and requirements of the Children Act are not automatically applied to YOIs and other prison establishments. In one YOI, not all policies and procedures to safeguard young people were in place. Arrangements for responding to and investigating complaints by young people were not satisfactory, and in one YOI, there were two staff suspended following allegations of assaults on young people that had not been resolved after many months.

8.10 The major threat to young people is not from the staff: where there were concerns about staff behaviour, these were generally responded to promptly. There was, however, a high level of violence

between young people.

8.11 Arrangements for the investigations of allegations of assault and abuse by young people needed to be demonstrably robust. There were not protocols in all YOIs that ensured the victim felt confident their complaint was being taken seriously: the systems lacked credibility.

8.12 We saw good practice where one social services department was investing staff time and resources to work with the YOI staff and probation staff to address safeguarding issues, and, in comparison with other YOIs, the impact was very significant. Good procedures had been drawn up, young people in the YOI had participated in this, and they were relevant and appropriate to the institution. A group of inmates had worked with staff to produce a video that raised awareness about the extent of bullying and that it should not be tolerated.

GOOD PRACTICE

Staffordshire social services were investing staff time to work with colleagues from probation and the YOI staff to develop effectively a safeguarding culture at Brinsford YOI.

8.13 In one area, the ACPC had deliberately held one of its meetings within the YOI, to make all members of the ACPC aware of their responsibilities towards these young people.

8.14 In all other areas, there was a lack of engagement with YOIs and the young people in them, despite the fact that there were large numbers of young people who were at serious risk of significant harm in these institutions.

8.15 Tragically, some young people in YOIs die in custody. It was brought to our attention that there was a lack of clarity about who was responsible for investigations into deaths in YOIs. This needed to be resolved.

8.16 We found that in only one area inspected was the YOT represented on the ACPC. Nottingham ACPC had actively addressed the safeguarding needs of young people who commit offences, and taken active measures to engage with the work of the YOT staff. In no other area was the ACPC seeking to address their responsibility for the welfare of these young people.

8.17 We inspected files of YOT workers, and found that the focus

was almost exclusively upon the offending behaviour of the young people, and there was little evidence of welfare needs being considered and addressed. To compound the difficulty, many young people who commit offences were being placed in YOIs at a great distance from their home areas, due to the pressures on the system. This made it difficult for YOT workers to attend reviews and meetings, or maintain any contact or provide any support to the young people.

8.18 The work of YOT staff was rather detached from other services. The focus of their work was on offending behaviour, and they were not providing appropriate risk assessments in respect of these young people being placed in YOIs.

Conclusions

8.19 Young people in YOIs still face the gravest risks to their welfare, and this includes those children and young people who experience the greatest harm from bullying, intimidation and self-harming behaviour.

8.20 The work of the YOTs was detached from other services, and there was only limited evidence that they were addressing safeguarding issues. The focus of their work with young offenders was almost exclusively on their offending behaviour, and did not adequately address assessing their needs for protection and safeguarding.

8.21 In only one area was the work of the YOT integrated into the work of the ACPC: they were not even represented on ACPCs in most areas. Similarly, ACPCs were not engaging with the welfare of young people in YOIs.

8.22 We concluded that ACPCs need to make a major commitment to the welfare of young offenders who are receiving services from YOTs and particularly those in YOIs. We also concluded that there needs to be a comprehensive inspection of YOIs and their working relationships with ACPCs.



9 Protecting Children from Potentially Dangerous People

Introduction

9.1 The police and probation services also contribute to safeguarding children in the work they do to prevent offending by people assessed as presenting a high risk of harm to children.

9.2 Under the Criminal Justice and Court Services (CJCS) Act 2000 (27), each police force and probation area is required to establish joint arrangements for the assessment and management of the risks posed by sexual, violent and other offenders who may cause serious harm to the public. Multi-Agency Public Protection Panels (MAPPPs) have been set up, led by police and probation, with health, social services, housing and other appropriate agencies sending representatives.

9.3 Initial Home Office guidance set out the minimum requirements for these arrangements, and we examined how well the local arrangements were working in each area inspected.

9.4 Because of the important part they play in the management of potentially dangerous offenders in the community, we also wanted to assess the effectiveness of:

- the Sex Offenders Register;
- the use of external controls on offenders who pose a high risk to the public, including children;
- arrangements in respect of unconvicted people who pose a high risk of harm to children.

9.5 Finally, we considered how well the lessons from an earlier review of serious incidents committed by offenders under the supervision of the probation service had been implemented.

Findings

9.6 The Home Office Dangerous Offenders Steering Group (an inter-agency high level strategy group) was in the process of developing a national strategy for the assessment and management of potentially dangerous offenders. In the meantime, policy and guidance was being developed and issued by the Dangerous

Offenders Unit, based in the National Probation Directorate. It was staffed by representatives from both police and the National Probation Service with a broad brief for supporting the management of cases and development of policy. They had issued the initial guidance for Multi Agency Public Protection Arrangements (MAPPA) setting out the minimum requirements, and had specified the structure and content of annual reports, to be published for the first time in July 2002.

9.7 The unit, in collaboration with others, had an ambitious programme of development including:

- national standards and performance indicators for MAPPA and public protection practice;
- lay involvement in MAPPPs – recruitment was under way for local representatives to participate at a strategic level in the planning of arrangements to manage potentially dangerous offenders in the community;
- Circles of Support – an interesting initiative to provide support and accountability when sex offenders are released from prison into the community;
- Stop It Now – a project providing information to the public on protecting children from sexual abuse.

9.8 Although progress was being made in developing a national framework for assessing and managing potentially dangerous offenders, there had been insufficient strategic focus nationally in order to ensure the effectiveness and consistency of local arrangements. There was also a need to make specific links nationally and locally with strategic developments and networks relating to the protection of children, in order to ensure that the particular needs and circumstances of children were taken into account.

The Structure of the Multi-Agency Public Protection Panels

9.9 Inspectors found a variety of MAPPA. Most areas visited had a high level inter-agency strategic group, which developed and monitored the implementation of policy. Membership and commitment to this group varied. For example, local authority housing departments were involved in some but not all areas. This had implications for arrangements made to provide suitable accommodation for potentially dangerous people that would contribute to the management of the risks they presented. Social services representatives were more effective when their role involved management of child protection services or their equivalent.

9.10 At an operational level, some areas convened routine meetings to discuss a range of cases, whilst others considered only single cases.

A number of areas had a two-tier arrangement for higher and lower risk of harm cases. These arrangements had developed to meet local needs and preferences, and did not always meet minimum requirements as set out in the national guidance.

9.11 We found that both police and probation representatives chaired MAPPPs and that none had received specific training for that role. Such training did not appear to be available locally or nationally. Some areas had a dedicated administrator, and a number were discussing establishing joint public protection units.

GOOD PRACTICE

In Nottingham the six member agencies of the MAPPP had jointly funded a co-ordinator. This resulted in more efficient operation and better communication.

9.12 Records of meetings lacked adequate detail, did not contain a sufficient risk management plan or detail how decisions had been reached. None seen contained an adequate assessment of risk or protective factors, and triggers. It was of concern that a fifth of the relevant probation files examined did not contain a copy of the MAPPP minutes.

Referrals and Levels of Risk

9.13 We found that in many areas there was confusion about terminology, both within and between agencies, in the absence of nationally agreed definitions, and we found different terms being used. For example, when referring to ‘dangerous offenders’, some people included sex offenders, whilst others saw them as a separate category.

9.14 The lack of clarity regarding definitions was likely to have contributed to the considerable variation in the thresholds for referrals to MAPPPs. A national survey of probation areas found that the proportion of the caseload on their public protection register ranged from 0 to 25 per cent, and that the proportion of those who were referred for discussion at MAPPPs ranged from 0 to 100 per cent. The high level of referrals, some of them inappropriate, had implications for the resourcing of MAPPPs, whose use should be restricted to the ‘critical few’ who pose a very high risk of harm.

9.15 Many areas were unable to assess data because MAPPP referrals had not been monitored. Few areas visited used a formal referral process. This led to inconsistencies in the level of information on each offender considered by MAPPPs. Inspectors considered that in a quarter of probation cases examined, referrals should have been made earlier.

Assessment of Offenders

9.16 The comprehensive and accurate initial screening and assessment of offenders is vitally important because of the impact this has on the actions taken subsequently to manage identified risks. Inspectors found that assessment procedures varied. All police forces used Matrix 2000 to assess sex offenders, but most MAPPPs appropriately supplemented this with locally gathered intelligence. Probation assessment tools differed, with most areas using a proforma to assess risk of harm to the public, self and staff. The probation file reading exercise showed that there was some room for improvement in the quality of assessments and particularly in the extent to which they addressed risk to children. In only 66 per cent of cases was an initial screening or assessment of the risk of harm to children done, and where it had been, only 73 per cent were of a satisfactory standard. Where a full assessment had been done 88 per cent were good enough or excellent.

9.17 Agency based assessments were fed into the MAPPP discussions and decisions made on the basis of all available information. A new assessment tool – OASys – was about to be introduced. It had been developed jointly by prison and probation services and would replace existing assessment, supervision and sentence planning tools. It contained a section on specific risks to children and represented a considerable improvement. Both probation and police staff expressed positive views about OASys. There needed to be national guidance on an unresolved question about police access to OASys assessments in the context of MAPPPA.

9.18 A decision about the level of risk and management plans were the main outputs from MAPPP meetings. In the four MAPPP meetings observed there was a clear statement of the current level of risk of harm of each individual offender. The focus in some meetings tended to be on the offender, rather than potential victims, and a number of cases would have benefited from this different perspective, e.g. when placing a sex offender in new accommodation, a risk assessment of the environment with a focus on potential victims in the area could have been carried out.

Resourcing of the MAPPPs

9.19 In the absence of national guidance, there was considerable variation in levels of resourcing, and in no area was there a joint planned approach to workload management. Levels of management, practitioner and administration time available for MAPPPs were different in each area affected by the lack of an agreed national formula for resourcing. Without this, MAPPPs were vulnerable to short-term changes in priorities and the reassignment of resources at short notice.

Review of Cases and Effectiveness of the MAPPPs

9.20 In all areas there was a mechanism to review individual cases, normally by setting a date to do so at the MAPPP. However, in most there were no arrangements in place for reviewing the effectiveness of the MAPPP itself, including the different models adopted. The monitoring requirements set out in the recent guidance for annual reports focused on volume rather than quality issues. In some areas, police and probation managers had carried out a joint audit of high risk of harm cases. These focused on the management of the individual cases rather than on the overall effectiveness of the MAPPP itself.

GOOD PRACTICE

In Surrey, the crime manager and the assistant chief officer (probation) met every three months to evaluate cases dealt with by the MAPPP, with the intention of developing good practice and ensuring that no information had been missed or not acted upon.

9.21 The probation file reading exercise found that the work done by the national probation service in collaboration with the police and other agencies, and the actions taken to prevent the risk of harm to children, was done well in 78 per cent (32 relevant files) of cases. There were two cases where further harm to a child had occurred: in one the probation area had taken every reasonable step to prevent this happening and in the other it had not.

The Sex Offenders Register

9.22 Inspectors found that in all areas visited, police officers were using Matrix 2000 to assess the static risks posed by sex offenders, but as far as dynamic risks were concerned, the response varied. There was some confusion amongst police officers about the different versions of Matrix 2000. There were three versions – one designed for sex offenders (RM2000(S)), one for violent sex offenders (RM2000(C)) and one for violent offenders (RM2000(V)) – and a lack of clarity about which versions were in use.

9.23 It was evident that not all forces visited were using all the available information to assess risk of harm. For example, information about the original offences available at the time of sentencing was not always easily accessible to the police involved in the management of the case. This information is critical if a comprehensive risk assessment is to be undertaken.

9.24 The actual management of offenders also varied from area to area visited. Some forces had prescriptive visiting timetables depending on the risk of harm posed by the offender. In other areas,

the MAPPP determined how often an offender would be visited. Very high and high risk of harm offenders were given priority, but in some areas there was little or no supervision being conducted with medium and low risk of harm offenders, which caused inspectors some concern.

9.25 Surveillance was being conducted by most forces to gather evidence in relation to the 'lifestyle' of the individual or if it was suspected that there was possible criminal activity. However, all interviewees stated that due to the cost of running surveillance operations, it usually meant that it could not be sustained over long periods of time. It was noted that other agencies, such as the probation service and housing departments, were willing to assist with gathering information when appropriate.

9.26 Concern was shown by officers that no national database had yet been established to register sex offenders. The implementation of Violent and Sex Offenders Register (ViSOR), a national database of sexual and violent offenders, was eagerly anticipated.

Controls on Offenders who Pose a Risk of Harm to Children

9.27 External controls are the range of measures available to the police and national probation services designed to manage offenders effectively in the community. They include court orders and prison licences but also a wide range of other options such as surveillance and the use of intelligence sources. Measures can either require an offender to refrain from certain activities, eg contacting or going near the victim(s) of their offence(s), or undertake a specific activity, eg attend a sex offender programme, or to reside in an approved probation premises.

9.28 There was good use of additional requirements and licence conditions evidenced in case records; in 22 out of 42 cases specific measures were added to licences or orders.

GOOD PRACTICE

One licence had focused additional conditions designed to stop the offender entrapping or enticing children and prohibiting him from playgrounds and communicating with or photographing children.

9.29 The probation file reading of MAPPPs cases found that:

- 14 out of 42 offenders had a condition to attend a treatment programme, 10 of which were specifically for sex offenders;
- in 11 out of 42 cases it had been specified that victims were not to be contacted or approached;

- two people were explicitly excluded from the victim's neighbourhood;
- five offenders were not allowed any contact with children;
- seven were prevented from working or living with children;
- eight were required to live at a specific address.

9.30 Through the MAPPA all relevant agencies were able to influence risk management plans and the use of external controls. Other agencies were also prepared to contribute to monitoring the effectiveness of external controls, eg housing managers, where represented, were able to provide information on the movements of high risk offenders.

9.31 The use of Sex Offender Orders varied throughout the country. Some interviewees reported that there was some reluctance to apply for them because of the perceived difficulty in bringing a successful case and because there were significant resource considerations in monitoring an offender's compliance with the order.

9.32 Most recently available options had been used less often by the areas visited. The Disqualification Order makes it an offence for an offender to apply for a job working with children. The Restraining Order can be imposed, by the Crown Court, on any offender convicted of a sexual offence and sentenced to a period of imprisonment, and may prohibit the offender from doing anything described in the order. Both options have to be made at the time of sentence.

Unconvicted People and Itinerant Offenders

9.33 All forces visited reported that the management of unconvicted persons or offenders who fall outside of the Sex Offenders Act (24) was more problematic. If risks were identified through intelligence, they were managed in the same manner as registered sex offenders, although officers complained that they had no legislative powers to assist them. In reality those acquitted of sex crimes were unlikely to co-operate with the police or any other agency. Inspectors found that no force had written strategies in place regarding itinerant offenders or offenders who travel abroad.

9.34 As far as links with the National Criminal Intelligence Service (NCIS) were concerned, most forces stated that they did not receive much information from NCIS and were not really sure of the remit. One senior officer stated that he had written to NCIS in October 2001 in relation to the management of offenders who travel, and despite many further enquiries, had still not received any guidance.

9.35 NCIS had developed a database that stored the details of all unregistered or untraceable sex offenders and assisted police forces with enquiries to trace the individuals. It also developed an intelligence package devised to capture information relating to persons suspected of travelling abroad to commit sex offences against children.

9.36 A representative of NCIS was interviewed and reported that, since April 2001, there had been 201 intelligence packages disseminated to forces regarding persons suspected of committing offences against children. It was accepted that a large proportion of practitioners did not understand the nature of 'their business' and more needed to be done to market the facilities provided by NCIS.

9.37 There was evidence during visits to areas that probation staff offered advice and support to the police for cases not currently under their supervision but where they could contribute to the management plan. These arrangements were ad hoc and not normally written into protocols but were seen as having great value.

Serious Incident Reviews

9.38 There have been several sets of guidance (55) requiring probation areas to identify, review and report on cases where an offender under probation supervision committed a very serious violent or sexual offence. These are called serious incident reviews.

9.39 As part of this inspection, HMI Probation carried out an audit of serious incident reviews for 2001-2002. It was found that:

- Management reviews did not always contain a comprehensive review of the offender assessment and so it was difficult to establish if factors had been identified that may have predisposed the offender to sexual or violent offending. Thirty-two offenders had a previous conviction for sexual and/or violent offences, although this did not always indicate specific risk to children.
- Most cases had been managed to National Probation Service standards, and in the majority it would have been difficult for staff to predict the new offence. However, in a small number of cases they could have taken steps which may have had an impact on the outcome.
- Lessons learned from the review of these cases were not being disseminated nationally.
- No links had been made between Chapter 8 serious case reviews and serious incident reviews. This meant that probation and social services managers sometimes adopted different processes for a similar task.

- A National Probation Service review of the system for the notification and scrutiny of serious incidents was under way at the time of the inspection.

Conclusions

9.40 Progress was being made in developing a national framework for assessing and managing potentially dangerous people, but there had been insufficient strategic focus nationally to ensure the effectiveness and consistency of local developments.

9.41 The level of co-operation and collaboration between police and probation staff at all levels and in every area inspected was impressive.

9.42 The representation on and resourcing of MAPPPs varied, and the lack of a statutory footing made them vulnerable to short-term changes in priorities. At the time of this inspection, the Home Office was considering establishing MAPPPs on a firmer statutory basis. We recommend this is pursued. Training for police and probation staff who chaired MAPPPs was not available.

9.43 All areas had produced an information sharing protocol, which most agencies had signed up to. Some were not fully up to date. Information about original offences was often inadequate for those police officers conducting assessments of registered sex offenders.

9.44 Risk management plans and reviews needed updating.

9.45 In some areas inspected offenders, required to register with the police under the Sex Offenders Act 1997 and assessed as being of lower risk of harm were not subject to appropriate regimes of monitoring.

9.46 Formal links between ACPCs and MAPPPs had not been established in most areas.

9.47 Lessons learnt from reviews of serious incidents involving those subject to probation supervision were not disseminated nationally.

9.48 The development of a national database, ViSOR, was a positive initiative which had the potential to make a significant contribution to the management of potentially dangerous people.



Appendix A Role and Remit of Inspectorates

Social Services Inspectorate (SSI)

The Social Services Inspectorate is a professional division within the Department of Health. Its key responsibilities are to:

- provide policy advice within the Department of Health;
- manage the Department of Health's links with councils with social services responsibilities and other social care agencies;
- inspect the quality of social care services in accordance with legislation, statutory guidance and established best practice;
- assess the performance of local councils in delivering their social care functions and in accordance with Best Value legislation and guidance.

SSI currently undertakes these functions through:

- a programme of inspections to regularly evaluate the quality of aspects of social services in all local councils;
- a programme of joint reviews with the Audit Commission to assess local councils' performance and use of resources across the range of their social services functions;
- monitoring councils' progress in implementing key aspects of government policy including those at the interface with health;
- assessing the performance of local councils with social services responsibilities, leading to star ratings.

SSI inspects children's services in each council at least once every five years and undertakes targeted inspections of child protection services where there are indications of concerns. Over the last few years SSI has also undertaken thematic child care inspections in areas such as adoption, services for ethnic minority children and families, and private foster care. SSI also inspects local authority secure accommodation in support of the Secretary of State's licensing responsibilities.

Office for Standards in Education (OFSTED)

OFSTED is responsible for:

- inspecting maintained schools and colleges, and some independent schools and colleges;

- inspecting LEAs;
- registering and inspecting daycare provision for children aged under eight;
- undertaking surveys on key issues; and
- reporting findings to the Department for Education and Skills (DfES).

OFSTED undertakes inspections of all primary and secondary schools in the maintained sector every six years, with more frequent inspections of schools causing concern. It inspects all provisionally registered independent schools, including those catering wholly or mainly for pupils with special educational needs, and all finally registered independent schools that are not members of the Independent Schools Council (ISC). As independent special schools are not members of ISC, they and other non-ISC schools are inspected on a five-year cycle. Jointly with the Audit Commission it undertakes inspections of each of the 150 LEAs on a regular basis. OFSTED inspectors also undertake joint inspections of secure units and Young Offender Institutions (YOIs).

Activity relevant to safeguarding children includes special survey inspections and inspections of LEA functions, as well as regular checks within inspections of daycare, maintained schools and those independent schools within OFSTED's remit.

Commission for Health Improvement (CHI)

CHI is a non-departmental public body, covering England and Wales, established under the 1999 Health Act (56). While being independent of Government, CHI has a responsibility to report to Ministers on the quality of patient care. It has a key role in assisting the NHS to identify and address unacceptable variations in patient care and to ensure a consistently high standard.

CHI undertakes four key activities:

- to investigate serious concerns in health services;
- to undertake clinical governance reviews in every NHS organisation;
- to study the implementation of National Service Frameworks and guidance from the National Institute of Clinical Excellence (NICE); and
- to provide advice and guidance to the NHS.

While none of this activity has a specific focus on children's safeguards, reviews have included children's services, and all



**Her Majesty's
Inspectorate of
Constabulary (HMIC)**

inspections and reviews will identify and follow up any areas of concern.

The purpose of HMIC is to promote the efficiency and effectiveness of policing in England, Wales and Northern Ireland through inspection of police organisations and functions to ensure:

- agreed standards are achieved and maintained;
- good practice is spread; and
- performance is improved.

HMIC provides advice and support to the Home Office and police authorities on all related matters.

HMIC conducts three types of inspections:

- force inspections annually or as required. Following a risk assessment it is determined whether the inspection covers all activities of the force or specific areas;
- basic command unit inspections across all functions every five years; and
- thematic inspections.

Police responsibilities towards child protection and children's safeguards will be covered within these inspections but rarely to any depth. HMIC undertook a child protection thematic inspection in 1998 (42).

**Her Majesty's
Inspectorate of the
National Probation
Service for England and
Wales (HMI Probation)**

HMI Probation is independent of the Home Office and the National Probation Service reporting directly to the Home Secretary. It contributes to the Home Office aims of:

- ensuring the effective delivery of justice;
- effective delivery of custodial and community sentences to reduce reoffending and protect the public; and
- ensuring the effective independent scrutiny of prison and probation services.

HMI Probation reports to the Home Secretary on the extent to which the NPS is fulfilling its duties, and provides advice and dissemination of good practice to Ministers, Home Office, criminal policy group, the National Probation Directorate and local probation boards and staff.

HMI Probation carries out four main activities:



Role and Remit of Inspectorates

- a three-year rolling programme of performance inspections within each probation area;
- thematic inspections, including some jointly with other inspectorates;
- audit of accredited programmes;
- focused small-scale inspections on particular topics or services.

Inspection activity will include examination of issues relevant to the management of dangerous offenders and the service's responsibilities towards safeguarding children. Some recent thematic inspections focused on related areas of activity.

Her Majesty's Inspectorate of Prisons (HMI Prisons)

HMI Prisons is independent of the prison service, reporting directly to the Home Secretary. The inspectorate's primary responsibility is to monitor the treatment of prisoners and the conditions and management of prisons in England and Wales.

HMI Prisons undertakes:

- a full inspection of all HM Prison Service establishments every five years with intervening unannounced inspections if necessary;
- a full inspection of the 17 YOIs every three years by HMI Prisons on behalf of both the Home Office and the Youth Justice Board (YJB), with whom these establishments have a contractual arrangement;
- additional unannounced or announced inspections of YOIs as necessary;
- in addition, each YOI will receive an annual inspection of the education, training and supporting regime.

Both full and annual inspections of YOIs include children's safeguards as a central component of the inspection focus. Similarly, inspections of other prison establishments will also examine arrangements to safeguard and protect children.

Her Majesty's Magistrates' Courts Service Inspectorate (HMMCSI)

HMMCSI is required to inspect and report to the Lord Chancellor on the organisation and administration of the magistrates' courts for each committee area. Since April 2001 HMMCSI has a specific responsibility to inspect and report to the Lord Chancellor on the performance of the Children and Family Court Advisory and Support Service (CAFCASS). This inspection activity includes:

- all ten CAFCASS regions have been subject to structured visits during 2001;

**Her Majesty's Crown
Prosecution Service
Inspectorate (HMCPSI)**

- from March 2002 all regions will be subject to regular inspections;
- all inspection activity focuses on child welfare considerations and activity, and identifies aspects relevant to safeguarding children.

The purpose of HMCPSI is to promote the efficiency and effectiveness of the CPS through a process of inspection and evaluation; the provision of advice; and the identification and promotion of good practice. HMCPSI inspects each of the 42 CPS areas, together with some headquarters directorates, on a two-year cycle. It also conducts thematic inspections, some jointly with other inspectorates. Its aims are:

- to inspect, evaluate, report and make recommendations on the quality of casework decisions and processes and other relevant aspects of the work of the CPS;
- to carry out thematic reviews of particular topics which affect casework or the casework process;
- to give advice to the Director of Public Prosecutions on the quality of casework decisions and the casework decision making processes of the CPS and other relevant areas of performance;
- to identify and promote good practice; and
- to work with other inspectorates to improve the efficiency and effectiveness of the criminal justice system.

Inspection activity of particular relevance has included the consideration of child abuse cases within each area inspection and the undertaking of a thematic inspection of cases involving child witnesses.

Appendix B Standards and Criteria

STANDARD 1

ARRANGEMENTS BY AGENCIES TO SAFEGUARD CHILDREN

All agencies whose staff (including volunteers) have contact with children and/or families have in place clear policies, strategies and procedures to ensure the safeguarding of children.

Criteria:

- 1.1 Agencies have clear strategic plans and policies that prioritise the safeguarding of children and promote their welfare, and involve users and their representatives in the development of these plans.
- 1.2 All agencies working with children and families plan and develop services within the common framework of the local community safety and children's services plans.
- 1.3 All agencies have clear policies to promote equalities issues and monitor services to ensure that no child is discriminated against due to age, gender, race, culture, religion, language, disability or sexual orientation.
- 1.4 Managers and/or senior staff ensure that staff and volunteers are aware of their responsibilities to ensure the safeguarding of children and have received training to enable them to fulfil this responsibility.
- 1.5 Recruitment policies and procedures conform with legislation and guidance.
- 1.6 Staff (including volunteers) have their safeguarding checks updated as required by legislation and guidance, and these are properly recorded.
- 1.7 Foster carers and other people in their homes are checked, and these checks are updated, as required by legislation and guidance.



Standards and Criteria

- 1.8 Managers and/or senior staff ensure that staff listen to and respond appropriately to the concerns of children and young people.
- 1.9 Managers and/or senior staff promote a culture within their agency that ensures children as individuals are respected at all times and that their welfare is promoted.
- 1.10 Agencies have effective complaints procedures and whistle-blowing arrangements.
- 1.11 Managers and/or senior staff ensure that staff are effectively supported and protected from danger and/or the risk of violence.
- 1.12 Agencies have clear procedures in respect of allegations against staff, volunteers and others with the care of children, and monitor and ensure the effectiveness of these procedures.

STANDARD 2**THE SAFEGUARDING OF CHILDREN IN ALL SETTINGS AND CIRCUMSTANCES**

Agencies have local policies and procedures that address the safeguarding of children living away from home and in other circumstances where they are known to be particularly vulnerable.

Criteria

- 2.1 The ACPC procedures cover all situations where children live away from home.
- 2.2 Agencies have in place clear and unambiguous procedures in respect of child protection, consistent with local ACPC arrangements, in all settings where children live away from home, and monitors the implementation of them.
- 2.3 Local safeguarding arrangements address equalities issues and ensure the children do not experience discrimination, and receive protection when they require it.
- 2.4 There are clear policies and procedures that are monitored in respect of any allegations made against any professional, carer, foster carer or volunteer in any situation where children are living away from home.
- 2.5 The ACPC has in place and monitors a protocol with the Youth Offending Team that addresses issues of safeguarding in respect of all children and young people who commit offences against other people, including specifically the safety of all children and young people remanded or sentenced to custodial institutions.
- 2.6 The ACPC works with others to ensure that responses to issues of domestic violence by any agency address child safeguarding issues.
- 2.7 The ACPC, working with others has proactively addressed and put in place strategies to address the needs of children involved in prostitution or subject to sexual exploitation or go missing.

STANDARD 3**THE COORDINATION AND MONITORING OF THE CHILD PROTECTION SYSTEM**

The ACPC ensures agencies work collaboratively to develop and implement joint systems for ensuring the safeguarding of children, and monitors and evaluates the effectiveness of the child protection services.

Criteria

- 3.1 The ACPC is constituted as required by *Working Together to Safeguard Children* and has appropriate representation from all relevant agencies including those from the voluntary sector at an appropriate level of seniority.
- 3.2 The ACPC ensures that local policies, procedures and protocols are up to date, consistent with statute, Regulations and national Guidance, and fully owned by all local agencies involved with the protection of children.
- 3.3 The ACPC actively addresses issues of diversity and equality, monitors child protection, and takes action to address these where necessary.
- 3.4 The ACPC has adequate resources to fulfil its responsibilities.
- 3.5 The ACPC has put in place objectives and performance indicators for child protection, and uses management information in respect of child protection and safeguarding of children to improve services.
- 3.6 The ACPC has a regular programme to review local services to safeguard children, evaluates performance and takes action to improve effectiveness.
- 3.7 The ACPC has a Business Plan supported by robust planning processes, and this includes plans to address issues identified in reviewing and evaluating local services.
- 3.8 The ACPC encourages and promotes effective working relationships between different services and professional groups, based on trust and mutual understanding.
- 3.9 The ACPC has a strategy that is being implemented to raise awareness within the wider community of the need to

safeguard children and promote their welfare, and to explain to the wider community how they can contribute to these objectives.

- 3.10 Where the boundaries between the local authorities, the health service and the police are not coterminous, the ACPC has addressed the issues and sought to establish as far as possible common procedures and protocols, and sought to collaborate on inter-agency training.

STANDARD 4

HOW WELL DO LOCAL ARRANGEMENTS TO SAFEGUARD CHILDREN WORK?

Child welfare concerns are identified and responded to appropriately and sensitively with agencies working in partnership to ensure children are effectively safeguarded.

Criteria

- 4.1 Staff of all services in contact with children and/or their parents, have a clear understanding of their duties and responsibilities, and are trained and supported to identify potential child welfare concerns and know how to respond to them.
- 4.2 All services are provided in a way that ensures the safety of all children and respects the individuality of each child, and ensures there is no discrimination in respect of age, gender, race, culture, religion, language, disability or sexual orientation.
- 4.3 The Assessment Framework has been implemented on a multi-agency basis as an integral part of *Working Together*.
- 4.4 Staff of all services have a consistent understanding of the thresholds for sharing information with and referral to the SSD/Police, and the undertaking of an initial assessment to identify if the child is in need and, if so, if the child's welfare is being safeguarded.
- 4.5 Responses to child welfare concerns, including those that progress to Section 47 enquiries and core assessment, child protection registration, and the development, implementation and review of child protection plans, are conducted in accordance with local policies, procedures and guidance by all agencies.
- 4.6 Agencies in the judicial process have in place policies and procedures based on legislation and guidance that are implemented to support child protection services.
- 4.7 Plans for the protection of children set clear objectives to ensure their safety and are regularly monitored and reviewed by each agency to ensure that the plans are being implemented and are effective.

- 4.8 Responses to ensure the safety of children respect the rights, privacy and dignity of parents and carers as far as possible without jeopardising the child's safety, recognise the stress that such interventions can cause, and seek to ensure that families are supported and services to support parenting/care are put in place.
- 4.9 All agencies ensure that arrangements are put in place to safeguard children in any service they commission on behalf of children.



STANDARD 5

INFORMATION SHARING

Information for the purposes of safeguarding children is shared appropriately between agencies.

Criteria

- 5.1 There are clear protocols between the ACPC constituent agencies for the sharing of information.
- 5.2 There are systems in place to monitor, review and evaluate the sharing of information to safeguard children.
- 5.3 Agencies undertake regular audits in respect of the sharing of information, and act upon the findings to ensure that children are safeguarded.
- 5.4 Staff understand, accept and implement the protocols and guidance on information sharing.
- 5.5 Recording and sharing of information addresses the requirements of relevant data protection legislation, human rights legislation, anti-discrimination legislation and court proceedings legislation.
- 5.6 Case records kept by agencies in respect of children where there are welfare concerns, are accurate, up to date and of a high standard.

STANDARD 6**KNOWLEDGE AND SKILLS**

The ACPC ensures that staff (of the constituent bodies of the ACPC) who undertake work to safeguard children are well informed in respect of good practice and are appropriately skilled for the tasks.

Criteria

- 6.1 The ACPC has a strategic plan for inter-agency training of staff.
- 6.2 Staff of all ACPC constituent agencies are trained and supported in their work to protect children, and that this training is based upon up-to-date knowledge and skills.
- 6.3 The ACPC ensures that staff have the necessary knowledge and skills to protect children in a manner that is sensitive to issues of race, religion, culture and disability.
- 6.4 The ACPC and agencies ensure staff work to national and local guidance.
- 6.5 The ACPC has effective links to ensure that it keeps up to date with the growing body of research evidence and knowledge that should inform good policy and practice in work to safeguard children, including children from black and minority ethnic groups and those with a disability.
- 6.6 The ACPC has effective systems to ensure that its members and their agencies learn from local and national experience in respect of safeguarding children.

STANDARD 7**CASE REVIEWS CONDUCTED IN ACCORDANCE WITH CHAPTER 8 OF *WORKING TOGETHER TO SAFEGUARD CHILDREN***

The ACPC conducts case reviews under the guidance of Chapter 8 of *Working Together to Safeguard Children* effectively and ensures that appropriate lessons are learnt and changes to practice implemented to maximise safeguarding for children.

Criteria:

- 7.1 The ACPC has clear criteria consistent with the guidance for establishing a Chapter 8 case review.
- 7.2 The ACPC has established, when required, a Serious Cases Review Panel involving a minimum of social services, health, education and the police.
- 7.3 Serious case reviews are set up and conducted in a manner that is sensitive to issues of race, culture, religion and disability.
- 7.4 When a review is required, relevant agencies conduct individual management reviews to consider their involvement with the child and family, and identify changes that need to be made in individual and organisational practice.
- 7.5 The ACPC commissions an overview report that brings together and analyses the findings of the individual Management Reviews and any other reports commissioned, and includes an executive summary that is made public.
- 7.6 Recommendations from individual Management Reviews and the overview report are carefully considered by individual agencies and by the ACPC, with required changes in practice implemented within the timescales set out in the action plan.
- 7.7 The ACPC monitors action plans, and evaluates the effectiveness of their implementation.

STANDARD 8**REDUCING THE RISK OF SIGNIFICANT HARM TO CHILDREN FROM POTENTIALLY DANGEROUS PEOPLE**

The police and probation service in collaboration with other relevant agencies ensure that effective arrangements to assess and manage the risks posed to children by potentially dangerous people are being established, monitored and reviewed.

Criteria:

- 8.1 The Police and Probation Service have established effective systems to meet the requirements of Sections 67 and 68 of the Criminal Justice and Court Services Act 2000.
- 8.2 The Police have established a Sex Offender Register, which is monitored and reviewed, and the effectiveness of the register is evaluated.
- 8.3 The Probation Service and other relevant agencies make full use of legislation and other facilities to place external controls on offenders posing a risk to children.
- 8.4 The Police and Probation Service ensures staff are trained in identifying, assessing and managing the risk to children posed by potentially dangerous people.
- 8.5 The Probation Service has acted upon the recommendations of the HMIP Review of Serious Incidents.
- 8.6 The Police and other relevant agencies have arrangements in place to reduce the risks to children posed by unconvicted people who have been identified as posing a risk to children.
- 8.7 The Police and Probation Service and other relevant agencies have ensured that arrangements in respect of potentially dangerous people promote equality and are non-discriminatory.



Appendix C Methods Used in the Children's Safeguards Inspection

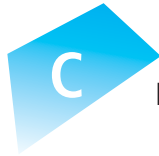
Prior to each inspection, the SSI arranged for the Area Child Protection Committee (ACPC) to complete a position statement, outlining how the local ACPC met the standards and criteria of the inspection. This was shared with all of the inspection team, who also obtained information and relevant documents for their respective agencies. The evidence for each inspection was collected in various ways by the different inspectorates. Each inspectorate undertook responsibility for the module relevant to their own service area but the Social Services Inspectorate (SSI) team members were also present for most of the interviews and group discussions. The following activity was carried out by the relevant inspectorates in each of the eight localities inspected:

Social Services Inspectorate

- a position statement was completed in relation to the standards and criteria. A range of documents was supplied to support these returns;
- questionnaires were completed by children's and families' fieldworkers;
- at least 20 case files were read in detail;
- a range of interviews were carried out with councillors, chief executives, managers and staff at all levels;
- personnel files were read;
- a number of files regarding allegations against council staff were read;
- individual and group interviews by members of the inspection team.

Commission for Health Improvement

- a questionnaire was completed on behalf of all the health organisations. A range of documentation was supplied and read in support of the questionnaire;
- group and individual interviews were carried out;
- a range of observation visits were made to such settings as Accident & Emergency (A&E) departments, paediatric wards, maternity services, GP clinics, a genito-urinary medicine (GUM) clinic and NHS Direct.



HM Inspectorate of Constabulary

- a range of documentation was supplied in relation to the standards and criteria;
- at least 15 case files were read in detail;
- group and individual interviews were carried out.

HM Inspectorate of Probation

- a national questionnaire was completed and a range of supporting documents was supplied;
- 54 child protection concern case files and 42 Multi-Agency Public Protection Panel (MAPPP) files were read;
- a number of group and individual interviews were carried out;
- four MAPPP meetings were observed.

HM Crown Prosecution Service Inspectorate

- a position statement was completed in relation to the standards and criteria;
- 12 case files were read in detail, including advice files, Magistrates' Court files and Crown Court files;
- interviews were conducted with managers, lawyers and caseworkers.

OFSTED

- a position statement was completed in relation to the standards and criteria. A range of documents and supporting material was supplied;
- group and individual interviews were carried out with relevant managers and professionals.

HM Magistrates' Courts Service Inspectorate

- a position statement was provided in relation to the standards and criteria;
- a number of files on completed care proceedings cases were read;
- interviews with children's guardians and team managers were carried out in regions and with Children and Family Court Advisory and Support Service (CAFCASS) headquarters staff. This included CAFCASS representatives on local ACPCs.

HM Inspectorate of Prisons

- YOT files were read;
- a telephone or face-to-face interview was usually undertaken with the YOT manager;
- in the one area in the sample that had a YOI in its locality, a visit was made to this unit and to two others for comparator purposes.



Appendix D Additional Relevant Inspection Activity

In addition to the joint inspection which produced the key findings for this report, all the participating inspectorates include children's safeguards or welfare within their routine inspection activity. See Appendix A for more details. The level of focus on these issues varies on whether the inspection has a particular theme or whether it is service wide. The emphasis on children's safeguards within inspection activity is also dependent on whether this is core business or high priority activity within the service area being inspected. Not surprisingly, the Social Services Inspectorate's (SSI's) inspections of council children's services and other specific service areas have a major focus on child protection and related safeguarding responsibilities.

Other examples include the Office for Standards in Education's (OFSTED's) emphasis on children's welfare, health and safety, and compliance with child protection procedures, within inspections of both schools and Local Education Authorities (LEAs); HMI Prisons' emphasis on the safety and welfare of young prisoners when inspecting Young Offender Institutions (YOIs); and HMI Constabulary's (HMIC's) examination of the work of child protection units within most police force inspections. While not focusing on safeguarding matters as such, the Commission for Health Improvement's (CHI's) Clinical Governance Reviews may select children's services for review, and identify and highlight areas of concern, as do their focused investigations and inquiries. The recommendations following the Kennedy Inquiry and the Investigation of Dr Peter Green have also had an impact on CHI's work with children's services. Reviews are now being undertaken at specialist children's centres. Each inspection by HMI Probation contains a focus on public protection, including the scrutiny of case records of offenders who present a risk of serious harm to children. Magistrates' Courts Service Inspectorate (HMMCSI) and Crown Prosecution Service Inspectorate (CPSI) inspections include aspects of child protection and safeguarding activity within their respective focus on parts of the court processes.

All Chief Inspectors publish annual reports, which contain a range of relevant material, and many inspectorates undertake specifically focused or themed inspections, some jointly with other inspectorates.

Recent reports publicising findings that are relevant to an examination of children's safeguards include:

- *Thematic Review on Young Prisoners* – HMI Prisons 1997 (57);
- *Someone Else's Children* – SSI 1998 (18);
- *Thematic Inspection of the Role of the Probation Services in Protecting the Public from Sex Offenders* – HMI Probation 1998 (58);
- *The Inspectorate's Report on Cases Involving Child Witnesses* – CPS January 1998 (Thematic Report 1/98) (59);
- *Thematic Inspection Report on Child Protection* – HMI Constabulary (assisted by SSI, HMI Prisons & HMI Probation) 1999 (42);
- *Suicide is Everyone's Concern*, a thematic review by HM Chief Inspectorate of Prisons 1999 (60);
- *Thematic Inspection of Lifers* by HMI Probation & HMI Prisons 1999 (61);
- *Annual Report of HM Chief Inspectorate of Prisons 1999/2000* – HMI Prisons (53);
- *The Victim Perspective: Ensuring the Victim Matters* – HMI Probation 2000 (62);
- *Excellence not Excuses- Inspection of Services for Ethnic Minority Children and Families* – SSI 2000 (47);
- *Who's Looking After the Children? Inspection of the Registration and Inspection arrangements for Under Eights Day Care Services* – SSI 2000 (63);
- *Developing Quality to Protect Children – Inspection of Children's Services* - SSI 2001 (39);
- *A Review of Case Administration in Family Proceedings Courts*. HM Magistrates' Courts Services Inspectorate 2001 (64);
- *Annual Report of HM Chief Inspector of Schools* – OFSTED (65);
- *Investigation into issues arising from the Case of Loughborough GP Dr Peter Green* – CHI 2001 (50);
- *Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary* Professor Ian Kennedy DH 2002 (51);
- *Setting Up – Report of a Programme of Visits to the Children and Family Court Advisory and Support Service* – HMMCSI 2002 (66);
- *Fostering for the Future – Inspection of Foster Care Services* - SSI 2002 (41).



Scope of Inspection Activity

The methodology of each inspection varies depending on the focus or topic of the inspection and the inspectorate(s) involved. All inspections, however, include an examination of relevant written material – policies, plans and procedures – and performance and monitoring data, followed up by interviews with key managers and practitioners. Most inspectorates incorporate observation of practice into their methodologies and interview users of the service being inspected. All inspectorates, with the exception of CHI, undertake file reading of a sample of service user case files and undertake case tracking activity. CHI has no defined powers to read user or personnel files.

SSI inspections include an examination of recruitment policies and practice within social services. All councils were found to have developed policies and procedures to check the suitability of staff working with children in line with the requirements of the Warner report (13) and other government regulations and guidance, although compliance with policy expectations varied. The SSI is the only inspectorate to examine systematically personnel files and recruitment processes within its inspection programme. Information on compliance with expectations in this area is not available for other settings.



Appendix E The Role and Responsibility of an Area Child Protection Committee (ACPC)

The role and responsibility of an ACPC is outlined in Chapter 4 of *Working Together to Safeguard Children* (3). This guidance states that all local authorities, in exercising their social services functions, should ensure that there is an ACPC covering their area, which brings together representatives of each of the main agencies and professionals responsible for helping to protect children from abuse and neglect. The ACPC is therefore an inter-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children.

The specific responsibilities of an ACPC as outlined in paragraph 4.2 of *Working Together to Safeguard Children* (3) are:

- to develop and agree local policies and procedures for inter-agency work to protect children, within the national framework provided by this guidance;
- to audit and evaluate how well local services work together to protect children, for example through wider case audits;
- to put in place objectives and performance indicators for child protection, within the framework and objectives set out in Children's Services Plans;
- to encourage and help develop effective working relationships between different services and professional groups, based on trust and mutual understanding;
- to ensure that there is a level of agreement and understanding across agencies about operational definitions and thresholds for intervention;
- to improve local ways of working in the light of knowledge gained through national and local experience and research, and to make sure that any lessons learned are shared, understood and acted upon;
- to undertake case reviews where a child has died or – in certain



The Role and Responsibility of an Area Child Protection Committee (ACPC)

circumstances – been seriously harmed, and abuse or neglect are confirmed or suspected. To make sure that any lessons from the case are understood and acted upon; to communicate clearly to individual services and professional groups their shared responsibility for protecting children, and to explain how each can contribute;

- to help improve the quality of child protection work and of inter-agency working through specifying needs for inter-agency training and development, and ensuring that training is delivered; and
- to raise awareness within the wider community of the need to safeguard children and promote their welfare, and to explain how the wider community can contribute to these objectives.

ACPC Membership

The membership of an ACPC should be determined locally but should include representatives of the main agencies responsible for working together to safeguard children:

- local authorities (education and social services);
- health services (both managerial and professional responsibilities);
- the police; and
- the probation service.

When active in the area, membership should also include:

- the domestic violence forum;
- the armed services; and
- the NSPCC.


The ACPC should make appropriate arrangements to involve others in its work as needed. Those with relevant interest may include:

- adult mental health services;
- child and adolescent mental health services;
- the coroner;
- the CPS;
- dental health services;
- drugs and alcohol misuse services;
- education establishments not maintained by the local authority;
- guardian *ad litem* panels (now replaced by CAFCASS);
- housing, cultural and leisure services;
- the judiciary;



The Role and Responsibility of an Area Child Protection Committee (ACPC)

- local authority legal services;
- prisons and youth detention centres;
- representatives of service users;
- sexual health services;
- voluntary agencies providing help to parents and children;
- witness support services; and
- youth offending teams.



Appendix F Minimum Requirements for Multi-Agency Public Protection Arrangements (MAPPA) and Panels (MAPPPs)

The *Criminal Justice and Court Services (CJCS) Act 2000* (22), sections 67 and 68, placed a duty on police and probation services to establish joint arrangements for the assessment and management of those offenders who present a risk of serious harm to the public.

In March 2001, initial guidance was issued setting out the minimum requirements for these arrangements in their first year of operation. They included:

- establishing strategic management arrangements for reviewing and monitoring the effectiveness of the arrangements made and for revising as necessary or expedient;
- establishing and agreeing systems and processes for sharing information and for inter-agency working on all relevant offenders;
- establishing and agreeing systems and processes to ensure that only those critical few that require additional consideration are referred to MAPPPs.

The criteria for referral were:

- imminence of serious harm;
 - may require unusual resource allocation;
 - serious community concerns;
 - media implications;
 - need to involve other agencies not usually involved.
- establishing and agreeing systems and processes for the MAPPP for the highest risk cases, including young offenders;
 - considering resource allocation and multi-agency training;
 - establishing community and media communications;
 - agreeing the annual report and statistics.



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Appendix H Glossary

A&E	Accident and Emergency
ACPC	Area Child Protection Committee
ACPO	Association of Chief Police Officers
CAFCASS	Children and Families Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CHI	Commission for Health Improvement
CJCS	Criminal Justice and Court Services
CPR	Child Protection Register
CPS	Crown Prosecution Service
DH	Department of Health
GP	General Practitioner
GUM	Genito-Urinary Medicine
HMCPSI	Her Majesty's Crown Prosecution Service Inspectorate
HMIC	Her Majesty's Inspectorate of Constabulary
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMI Probation	Her Majesty's Inspectorate of Probation
LCD	Lord Chancellor's Department
LEA	Local Education Authority
MAPPA	Multi-Agency Public Protection Arrangements



MAPPP	Multi-Agency Public Protection Panel
HMMCSI	Magistrates' Courts Service Inspectorate
NCIS	National Criminal Intelligence Service
NHS	National Health Service
NPS	National Probation Service
NSF	National Service Framework
OFSTED	Office for Standards in Education
PCT	Primary Care Trust
SSI	Social Services Inspectorate
YJB	Youth Justice Board
YJS	Youth Justice Service
YOT	Youth Offending Team
YOI	Young Offender Institution
ViSOR	Violent and Sex Offenders Register



Appendix I Area Child Protection Committee Areas Inspected

ACPC Areas Inspected

Hammersmith and Fulham

Harrow

Kent

North Yorkshire

Nottingham City

Shropshire

Stockport

Surrey

Appendix J Members of the Design Team and Editorial Board

Inspection Design Team

Richard Balfe	Social Services Inspectorate
Matthew Dieppe	Social Services Inspectorate
David Horne	Social Services Inspectorate
Chris Batty	Social Services Inspectorate
Steve Hart	Social Services Inspectorate
Jenny Gray	Social Services Inspectorate
Liz Fradd	Commission for Health Improvement
Maddie Blackburn	Commission for Health Improvement
Reg Pengelly	Her Majesty's Inspectorate of Constabulary
Di Askwith	Her Majesty's Inspectorate of Probation
Arran Poyser	Her Majesty's Magistrates' Courts Service Inspectorate
Maureen Eade	Office for Standards in Education
Jerry Hyde	Her Majesty's Crown Prosecution Service Inspectorate
John Rea-Price	Her Majesty's Inspectorate of Prisons

Editorial Board

Averil Nottage	Social Services Inspectorate
Matthew Dieppe	Social Services Inspectorate
Chris Batty	Social Services Inspectorate
Liz Fradd	Commission for Health Improvement
Maddie Blackburn	Commission for Health Improvement
Tim Hollis	Her Majesty's Inspectorate of Constabulary



Members of the Design Team and Editorial Board

Frances Flaxington	Her Majesty's Inspectorate of Probation
Di Askwith	Her Majesty's Inspectorate of Probation
Arran Poyser	Her Majesty's Magistrates' Courts Service Inspectorate
Kit Chivers	Her Majesty's Magistrates' Courts Service Inspectorate
Eileen Visser	Office for Standards in Education
Jerry Hyde	Her Majesty's Crown Prosecution Service Inspectorate
John Rea-Price	Her Majesty's Inspectorate of Prisons

Further Information

A Summary version of the full report *Safeguarding Children – A joint Chief Inspectors’ Report on Arrangements to Safeguard Children* has been sent to all relevant chief officers and the chairs of Area Child Protection Committees.

Further free copies of the main report and this summary can be obtained from:

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Email: doh@prolog.uk.com

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Main report and summary available on-line at www.doh.gov.uk/ssi/childrensafeguardsjoint.htm, and via other Inspectorate websites.

Individual Chief Inspectors and the Commission for Health Improvement will produce separate reports specific to their services. Information about these reports will be made available on their websites.