SAFEGUARDING CHILDREN

The second joint Chief Inspectors' Report on Arrangements to Safeguard Children

July 2005

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To: The Rt Hon Charles Clarke, Home Secretary
The Rt Hon Lord Falconer at Thoroton, Lord Chancellor
The Rt Hon Lord Goldsmith QC, Attorney General
The Rt Hon Patricia Hewitt, MP, Secretary of State for Health
The Rt Hon Ruth Kelly, MP, Secretary of State for Education and Skills

We are pleased to present our second joint report to Government on how well children are being safeguarded. It draws on a broad range of inspection activity across many agencies in England and additional studies of specific topics that we identified needed further scrutiny in the first review.

The report shows that:

- since our first report in 2002 the priority given to safeguarding children across agencies has increased and children are being listened to and consulted better. Agencies are also working better together to identify and act on welfare concerns;

- the policy commitment to safeguarding is not always reflected in practice and some agencies still do not give sufficient priority to safeguarding children;

- there are some specific concerns about the safeguarding arrangements for particular groups of children including disabled children, children living away from home and some children in health and secure settings.

The report makes a number of recommendations to government departments, national and local agencies. We are pleased that some of the areas that we have identified are already being addressed in the guidance to implement the Children Act 2004.

The report is presented by:

David Behan CBE, Chief Inspector, Commission for Social Care Inspection
David Bell, Her Majesty's Chief Inspector of Schools
Eddie Bloomfield, Her Majesty's Chief Inspector of Court Administration
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Sir Ronnie Flanagan GBE MA, Her Majesty's Chief Inspector of Constabulary
Ms Anne Owers, Her Majesty's Chief Inspector of Prisons
Anna Walker CB, Chief Executive, Healthcare Commission
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1. INTRODUCTION

SAFEGUARDING SINCE 2002

1.1. The landscape of children's services has changed considerably since the first Joint Chief Inspectors' Review of Children's Safeguards was published in 2002 [ref. 1http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm *and Appendix A*]. That review found that whilst all agencies accepted their responsibility to ensure that children were safeguarded, this was not always reflected in practice. Agencies were not always sufficiently committed to, or willing to fund, the work of Area Child Protection Committees (ACPC). Severe difficulties in recruiting and retaining professionals working in child protection and child welfare were also reducing the effectiveness of measures to safeguard children.

1.2. Over the last three years, there have been major developments in policy on children's services, influenced significantly by the first *Safeguarding Children* report and the Victoria Climbié Inquiry report [refs. 5 http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4004286&chk=PZKIDJ, and 48 http://www.everychildmatters.co.uk/_content/documents/keepingchildrensafe.pdf]. The *Every Child Matters* programme, underpinned by the Children Act 2004 [refs. 2 http://www.everychildmatters.gov.uk/_content/documents/Every Child Matinserts.pdf, *and 3* http://www.dfes.gov.uk/publications/childrenactreport/ - 2004], aims to improve outcomes for children in five key areas: being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being. The *National Service Framework for Children, Young People and Maternity Services* [ref. 58 http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098299&chk=dKtpA3] sets out a 10-year change programme across health and social care services and their interface with education, based on child-centred practice. Important changes in the youth justice system and the management of young people who commit offences have also helped to focus greater attention on children's safeguards.

1.3. At a local level, the priority given to safeguarding children across local government, health services and the justice system has increased in the three years since the last review and the status of work in child protection and child welfare has improved. There are examples of good practice and agencies are working together better to safeguard children. Nonetheless, some recurring themes over the past three years across sectors and agencies cause significant concern:

- Some agencies still give insufficient priority to safeguarding and children's interests and there are some groups of children, including those with

disabilities and those living away from home, whose needs are not always given sufficient recognition or priority;

- There are still considerable concerns about the differing thresholds applied by social services in their child protection and family support work and about the lack of understanding of the role of social workers by other agencies; and

- Continuing difficulties in recruitment and retention in some services affect their ability to safeguard children effectively and may restrict their capacity to deliver the new *Every Child Matters* arrangements.

1.4. These themes are considered in detail in this second report on safeguarding children, which seeks to identify what is working well and where improvements are still needed. It draws on a broad range of inspection activity across many agencies in England, including specific inspections on safeguarding issues which have been published separately, as well as providing evidence for this review. [1] It also draws on studies of topics identified in the previous report as needing more in-depth scrutiny, including:

- children with disabilities in educational settings;
- children who spend a long time in hospital;
- looked after children in out of area placements;
- children in family and criminal court proceedings;
- children seeking asylum; and
- children in custodial settings.

DEFINING SAFEGUARDING

1.5. At its simplest, safeguarding can be defined as "Keeping children safe from harm, such as illness, abuse or injury" [ref. 6 http://www.csci.org.uk/publications/childrens_rights_director_reports/safe_from_harm_report.pdf]. The first *Safeguarding Children* report noted that the term 'safeguarding' had not been fully or sufficiently defined in law or government

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[1] Her Majesty's Inspectorate of Constabulary, *Keeping Safe, Staying Safe: thematic inspection of the investigation and prevention of child abuse*, 2005.
HM Prison Service and Youth Justice Board, *Child Protection and Safeguards Review 2003: A review of safeguards arrangements for under-18s within the Prison Service juvenile estate*, 2004.
Her Majesty's Inspectorate of Court Administration, *Safeguarding children in family proceedings,* April 2005.
HM Inspectorate of Probation, *From Arrest to Sentence – the YOTs Role in the Safeguarding of Children,* 2005.

guidance. The Department for Education and Skills, in developing the framework for *Every Child Matters*, uses the standard definition of safeguarding from the *Framework for the Assessment of Children in Need and their Families* [ref. 17 http://www.archive.official-documents.co.uk/document/doh/facn/fw-00.htm]:

- protecting children from maltreatment; and
- preventing impairment of children's health or development [ref. 60 http://www.dfes.gov.uk/consultations/conDetails.cfm?consultationId=1303].

1.6. Even this does not fully encompass the more extensive concept of safeguarding that Sir William Utting promulgated in his 1997 report *People Like Us*.[2] He defined safeguarding as a distinct activity involving 'taking proactive steps to keep children safe' that incorporates more conventional child protection responses. At the time of the review the term therefore remained open to interpretation and this is reflected in its findings. Throughout this report, there are examples of a lack of understanding of, or engagement with, the term as it relates to individual agencies' work. However, at the time of writing this review, the Department for Education and Skills is consulting on future arrangements for safeguarding under the Children Act 2004 and has extended the definition to include proactively promoting the welfare of children. This will provide clear direction to all agencies.

1.7. For the purposes of this review, the definition of safeguarding that was used in the first review is retained:

- *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.*

1.8. A young person's guide to this review, called Keeping Children Safe, and a summary of the review, are available in print and on the website, www.safeguardingchildren.org.uk. The website also provides links to other inspection reports associated with this review, and a literature review with links to research and other publications relating to safeguarding issues undertaken since the first Joint Chief Inspectors' Review of Children's Safeguards was published in 2002.

[2] Utting, W. et al, *People Like Us – The Report of the Review of Safeguards of Children Living Away from Home,* The Stationery Office, 1997

2. SUMMARY OF KEY FINDINGS

2.1. This report explores how well public services safeguard children in a wide range of settings, including children who live at home and away from home, those involved in the justice system and those seeking asylum. A number of key themes run across many different settings, some of which reflect findings from the first *Safeguarding Children* report. Attention and effort are still needed to address them at both national and local levels.

Giving priority to safeguarding

2.2. The priority that is given to safeguarding children across local government, health services and the justice system has increased since 2002. More effort is devoted to listening to and consulting with children, there is increased commitment at executive and senior levels to safeguarding and it is more extensively embedded in policies and procedures.

2.3. However, the level of priority given to safeguarding still varies considerably between agencies that are involved with children. Some agencies, particularly in the justice system, have not yet sufficiently reflected upon what safeguarding means for their work and ensured that policy commitments to safeguarding are fully embedded in practice. Key findings include:

- Some agencies do not monitor how far the safeguarding ethos spreads throughout their organisation;
- There is an assumption that because children living away from home are already in care or under supervision, they must be safe, despite the considerable variations in children's own views on whether or not they are safe. This is reflected in some councils' failure adequately to monitor individual placements for children living away from home, especially contracts for placements of children outside their home area;
- Insufficient priority is given to the safeguarding needs of some groups of children, including: children with disabilities; those placed for adoption; young people aged 16-18 with a mental health condition or a chronic illness; children with a mental health condition admitted to secure settings; and vulnerable boys and girls of 15+ placed inappropriately in young offender institutions; and
- There is concern about how well settings that are currently unregulated safeguard children. These include educational provision through arrangements that are not registered as schools, armed forces recruitment and detention centres and private fostering arrangements.

2.4. At a strategic level, although there have been improvements, there is still considerable variation in the membership and effectiveness of Area Child Protection Committees. The development of Local Safeguarding Children Boards provides the opportunity to put in place more effective arrangements for local leadership, joint working, wider engagement, monitoring and review and sharing of good practice in safeguarding.

Giving children a voice

2.5. Some children feel they are adequately listened to and consulted. For example, many National Health Service (NHS) trusts have made considerable efforts to communicate with children appropriately and to seek their views in developing services; young people who commit offences are almost exclusively positive about their experiences with youth offending teams (YOTs); and there has been much attention given to seeking children's views in cases of domestic violence and improving support when they appear as witnesses in court. There are many other examples of creative and sensitive approaches to communicating and consulting with children.

2.6. However, many other children do not have sufficient opportunities to express their views or concerns. For example:

- there is insufficient account taken of the complexities of communicating with children with language and communication difficulties;

- social services do not consistently ensure that children looked after have contact with a range of reliable adults, such as independent visitors (where the child wishes it), or that social workers regularly visit children;

- most children involved in family proceedings have little or no say in the formal arrangements that will significantly affect their lives and they are not encouraged to attend court, except in adoption cases; and

- the concerns of children who are witnesses in court about the means by which they will give evidence are not always taken into account.

Behaviour management

2.7. The review raises particular concerns about the use of certain behaviour management techniques in many settings. These include the use of physical control, strip-searching and single separation or segregation in young offender institutions, local authority secure children's homes and secure training centres. There are also concerns about the over-use of physical control in children's homes, some special schools and some NHS settings.

Identifying and acting on welfare concerns

2.8. Agencies are working together better to identify and act on welfare concerns. There is greater clarity about roles and responsibilities, underpinned by protocols for operational co-operation and information sharing. In advance of the arrangements anticipated by *Every Child Matters*, some councils are already working effectively with partner agencies to enable children and families to access support services without needing to make unnecessary referrals to child protection services. Although the overall numbers of children on the child protection register have not reduced nationally, numbers have reduced in some areas. This indicates increased levels of trust between social services, education, health and youth justice services as well as better engagement from parents.

2.9. However, three years after the first *Safeguarding Children* report, there remain significant issues about how thresholds are applied by social services in their child protection and family support work. Key findings include:

- agencies other than social services are often unclear about how to recognise the signs of abuse or neglect, are uncertain about the thresholds that apply to child protection or do not know to whom they should refer their concerns. More attention needs to be paid to identifying welfare concerns for children with disabilities;

- largely because of resource pressures, some councils' social services apply inappropriately high thresholds in responding to child protection referrals and in taking action to protect children; and

- because some social services are unable to respond to families requiring support, other agencies do not refer children when concerns about their welfare first emerge. This means that some families are subject to avoidable pressure, children may experience preventable abuse or neglect and relationships between social services and other agencies may become strained.

These continued concerns raise questions about whether there will be sufficient capacity in all council areas to protect and promote the welfare of children effectively as well as achieving an appropriate balance between universal and preventative services within the new *Every Child Matters* arrangements. It also highlights the need to undertake further work to clarify roles and responsibilities across agencies in some areas.

2.10. In addition, arrangements for sharing information and joint working between agencies do not always work well and there can be delays in addressing risk factors, health issues and education needs. This is of particular concern where a council places children looked after in another council area without notification. There are also several areas in which arrangements need to be

clarified between agencies for young people who commit offences, including: when a young person has been in police custody, has been remanded into the care of the council or has been remanded in custody to a secure setting.

Workforce issues

2.11. Since 2002, the status of child protection and welfare work has increased, for instance in the police service. Recruitment and retention have improved in other services, such as education, and committed and skilled staff work with children in many settings. However, as the first *Safeguarding Children* review found, some services are under considerable pressure because of difficulties in recruiting and retaining adequately skilled and experienced staff, for example in social services and secure settings. Some agencies are adopting creative approaches to recruitment and retention. In others, staff shortages continue to have a detrimental impact on services' ability to safeguard children effectively.

2.12. Recruitment procedures and arrangements for checking that staff are suitable to work with children also continue to give rise to considerable concern. Checking of recruitment agency staff, contractors and staff from outside the United Kingdom (UK) and rechecking of existing staff with the Criminal Records Bureau are particularly inconsistent.

Children seeking asylum

2.13. Planning and providing services for the asylum-seeking children who have come to the UK in recent years is a challenging and complex task. It is complicated by many factors including: problems in responding to unpredictable numbers and unfamiliar cultures; the difficulty of reconciling immigration requirements and welfare considerations; disagreement and uncertainties about funding levels; and the scarcity of accurate information and inadequate information sharing.

2.14. The councils visited for this review are strongly committed to safeguarding asylum-seeking children. There are examples of effective dedicated services in health, education and the voluntary sector, and creative approaches to addressing some of the distinctive needs of asylum-seeking children, such as matching children with appropriate foster carers. However:

- inter-agency planning is often limited and identification of and information sharing about children in asylum seeking families are particularly variable;

- some councils place homeless families or unaccompanied looked after asylum-seeking children in other council areas without notifying the receiving council;

- child protection issues may not always be recognised. It is a significant concern that some children and young people are not identified and

protected, for example those who are privately fostered, or those who are in the country illegally;

- services for unaccompanied asylum-seeking young people of 16-18 and support for over-18s who were not previously in care are inconsistent; and

- there are considerable concerns about the welfare of children held with their families in immigration removal centres. There is a lack of effective guidance from the Immigration and Nationality Directorate, agreed with local ACPCs, on child protection arrangements to be applied in immigration removal centres and an absence of arrangements for welfare assessment and care planning for children in detention.

3. RECOMMENDATIONS

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

3.1 Give consideration in national consultation on Local Safeguarding Children Boards (LSCBs) to:

- developing appropriate links with the full range of agencies working with children in addition to the core agencies on Local Safeguarding Children Boards. This should include the courts, the Crown Prosecution Service and, where appropriate, the immigration service, including removal centres and local enforcement offices;
- the management of and dissemination of learning from serious case reviews; and
- accountability arrangements and responsibility for forward planning between the Local Safeguarding Children's Boards and the children's trust governance arrangements.

The Department for Education and Skills should:

3.2. Review arrangements to safeguard children where they are away from home in settings that are currently unregulated, such as sports, music or language centres etc. to ensure that appropriate regulation and safeguarding arrangements are in place. This review should also apply to armed services settings which accommodate children.

3.3. Reinstate the duty on social workers to visit children looked after at a minimum specified frequency and require social services, and subsequently, children's services, to monitor these arrangements effectively.

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

3.4. Issue one agreed set of principles for the use of control methods in all settings where children are cared for, including secure settings. This should take account of children's views and the need to place the use of physical control within an overall behaviour management strategy and in a wider context of prevention. Arrangements should be made for comprehensive accredited and/or approved training for staff.

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

3.5. Consider introducing national performance indicators for the police for child protection and the investigation of child abuse to give it due priority.

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

3.6. Ensure that clear guidance is drawn up for NHS organisations on role definitions and specifications for named and designated health professionals who have specific responsibilities for child protection, including arrangements to provide protected time to undertake this additional work.

The Youth Justice Board should:

3.7 Support youth offending teams in discharging their responsibilities by advising them on their strategic role on Local Safeguarding Children Boards and providing further direction on work to safeguard children and young people.

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

3.8. Promote the personal officer role as an integral part of the team in young offender institutions; and promote good practice in safeguarding children in prison custody, especially in relation to behaviour management and the care of particularly vulnerable children.

HM Courts Service and CAFCASS should:

3.9. Promote increased participation of children in family court proceedings.

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

3.10. Issue guidance to Immigration Removal Centres and local councils to ensure that:

- a care plan, incorporating good quality health, educational and social care provision, is drawn up at the point of detention for each detained child, following an assessment in line with the *Framework for Assessment of Children in Need and their Families* (2000);
- continuity of education is taken into account when children are detained;
- an investigation is carried out and a multi-disciplinary conference is convened by the local ACPC (or its successor Local Safeguarding Children Board) if the assessment shows the child to be at risk of significant harm under S.47 of the Children Act 1989, in line with *Working Together to Safeguard Children (1999)*;

- a multi-disciplinary review is in any event convened for any child to be detained for more than three weeks; and
- all assessments inform decisions on the necessity for continued detention.

All agencies and organisations directly involved with children should:

3.11. Review their approach to safeguarding, in line with the requirements of the Children Act 2004 and guidance, in order to:

- identify the relevant safeguarding issues specific to their area of work;
- ensure that there are policies and procedures in place to address these issues; and
- put in place regular quality assurance and monitoring systems to ensure that policy is followed through consistently in practice, and demonstrates effective outcomes.

3.12. Ensure that staff working with or in contact with:

- children with disabilities;
- children in private fostering situations; and
- asylum-seeking children,

know how to recognise the signs of abuse or neglect and which procedures to follow in such cases.

3.13. Audit their recruitment and staff checking procedures so that the following practices are carried out consistently:

- references are always verified and properly recorded in staff files;
- a full employment history is available on file for every member of staff, any gaps in employment history are checked and accounted for and qualifications are checked; and
- enhanced Criminal Records Bureau (CRB) checks are consistently undertaken on new staff and those working with children who have not previously been subject to checks, including temporary, agency or contract staff, prior to the establishment of the centralised vetting and barring scheme proposed in response to the Bichard recommendations.

3.14. Review existing safeguarding policies to ensure that they take full account of the needs of children with disabilities and assess the professional development needs of staff who work with children with disabilities to equip them to:

- communicate effectively with children;
- identify potential child protection concerns;
- track and monitor behaviour patterns; and

- follow appropriate child protection procedures.

Local councils and partner agencies should:

3.15. Ensure, when developing Children and Young People's Plans, that

- they reflect priorities for safeguarding as well as for universal and preventive services; and
- thresholds for specialist services are consistent with ensuring that children are safeguarded effectively.

Local councils should:

3.16. Ensure, in introducing the Common Assessment Framework, that sufficient priority and adequate resources are given to delivering their responsibilities to safeguarding children effectively.

3.17. Ensure that safeguarding requirements are consistently applied to looked after children in all settings, including:

- children placed for adoption;
- children on care orders placed with parents; and
- children placed with extended family.

3.18. Ensure that robust arrangements for safeguarding children looked after are in place, including:

- specific safeguarding requirements in all placement contracts; and
- effective monitoring arrangements, including regular visits by social workers.

3.19 Ensure that unaccompanied asylum seeking children receive a comprehensive assessment of their needs and that appropriate services are put in place.

3.20 Ensure, when children are placed in residential special schools, that their needs are assessed under the *Framework for the Assessment of Children in Need and their Families* to inform the care plan.

3.21 Put plans in place to ensure that good working relations between professionals, especially teachers and social workers, are actively promoted.

3.22 Develop parallel pathway plans for unaccompanied asylum seeking children who have been given discretionary leave to remain in the UK to age 18, taking account of the uncertainty about what immigration decision will be made at that time.

Local councils and NHS trusts should:

3.23 Establish clear arrangements, when a looked after child is placed out of their area, for notifying NHS Trusts in the area where they are placed, in line with the National Service Framework for Children, Young People and Maternity Services.

NHS trusts and independent hospitals should:

3.24 Develop robust protocols for:

- post-mortems, to ensure that staff are aware of the criteria for Serious Case Review, and how to request that a case is considered for a Serious Case Review through the Area Child Protection Committee (ACPC), and subsequently the LCSB; and know which cases of death must be referred to, or discussed with, the Coroner, and, for cases not referred to the Coroner, are familiar with the process of gaining consent for post-mortem examination; and
- ensuring that staff working with children who spend more than three months in hospital notify social services about these children to trigger an assessment, under the Framework for the Assessment of Children in Need and their Families, and follow up of their welfare needs.

4. CHILDREN LIVING AT HOME

INTRODUCTION

4.1. The majority of children live at home. This chapter focuses on children receiving universal services and children in need, including those in need of protection, children with disabilities and children on care orders who have been placed at home. It also considers children placed for adoption. Children encounter a wide range of agencies: schools, the NHS, and sometimes social services and the police. Also, agencies are increasingly commissioning services from the private and voluntary sectors as well as providing them directly.

4.2. This chapter looks at how well agencies safeguard children living at home, and, where possible, how children themselves feel about it. Some of the findings apply to children in all settings, not just those living at home. Evidence comes from mainstream inspections of social services, schools and other education settings and health services and from a recent thematic inspection of the investigation and prevention of child abuse by Her Majesty's Inspectorate of Constabulary [ref. 7 http://www.homeoffice.gov.uk/hmic/stayingsafe.pdf]. This chapter does not cover in detail the experiences of children and young people in the private and voluntary health sector, although safeguarding arrangements are an important feature of the regulation and inspection work the Healthcare Commission has carried out in that sector since April 2004. Detailed findings are included in the Healthcare Commission's published reports.

4.3. Special attention is given in this chapter to children with disabilities living at home, in line with the recommendation from the first *Safeguarding Children* report. Children with disabilities are especially vulnerable and research evidence suggests they are much more likely to suffer abuse and neglect than other children [refs. 8 http://www.nspcc.org.uk/inform/NWGCPD/ItDoesntHappenToDisabledChildren.asp, *and 9* http://www.anncrafttrust.org/publications.html#finalreport]. Welfare concerns sometimes go unnoticed because of the difficulties of identifying the signs of abuse or of communicating with some children, or because of reluctance by practitioners to suspect abuse.

4.4. There are varying definitions of disability in use. Alongside children with disabilities, we have considered other children with additional needs in this report in view of their increased vulnerability. This includes children with statements of special educational needs for emotional, behavioural and social difficulties as well as those with learning or physical disabilities. This chapter includes evidence about children with disabilities from social services and education inspections and from a special review of 10 special schools and 17 resource centres for pupils with special educational needs in mainstream schools.

LISTENING TO CHILDREN'S VIEWS

4.5. The importance of communicating and consulting with children and young people and listening to their views cannot be over-estimated. The *Victoria Climbié Inquiry Report* found that the consistent failure to communicate with Victoria was partly responsible for concealing her situation [ref. 10 http://www.rights4me.org.uk/whatyoutoldus/childrens+views+on+health/default.htm and http://www.csci.org.uk/publications/childrens_rights_director_reports/default.htm]. Children themselves have firm views on the subject:

> *'Treat us individually rather than as children as a whole.' [ref. 11 http://www.csci.org.uk/publications/childrens_rights_director_reports/childrens_views_green_paper_every_child_matters.pdf]*
>
> *'Listen to children like they matter and so you believe it.'* [3]
>
> *'Talk to us, not through our parents.' [ref. 13 http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en]*

4.6. There has been overall improvement since the first *Safeguarding Children* report. Agencies give more priority to recognising children's rights and views and to communicating with them and their parents. For example, some councils have developed special websites for children and provide dedicated advocacy services. Other councils are using innovative approaches with software programmes that help young people express their views in a child friendly way, as are some youth offending teams. In health settings, there is an increasing focus on listening to children to ensure that their needs are met and environments are suitable. Examples include children's or young people's groups, young people's websites and 'talking walls'[4] where children can express their views. However, some agencies give such initiatives higher priority than others. Also, the views of many children with disabilities are not heard because insufficient effort is put into overcoming the communication, sensory and/or learning barriers.

Good practice

Newcastle Hospitals NHS Trust actively seeks the views of children and young people, for example through their Children's Voices Project, and includes young representatives on the Patient Public Forum.

[Healthcare Commission/CSCI][5]

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[3] *Children's Views about Health Services*, Pat Doorbar Associates, 1995.

[4] A wall surface on which children can write or attach notes raising issues of importance to them.

[5] Names of inspectorates which have provided evidence for good practice boxes through the report

'This year when school council makes decisions it is acted upon. We have a good say in what goes on.' (Secondary school pupil with hearing impairment).

'I did not understand the words they were using…Nobody explained anything to me about going home…People told me different information and confused me.' [Ref. 14 http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en*]*

4.7. Survey results[6] suggest that children generally have positive working relationships with social workers and feel they are listened to. Out of 613 children, 48% (296) said they could always speak to their social worker and 29% (178) said they could usually do so. Similarly, in the majority of special education establishments, pupils feel safe. They feel staff take seriously what they say and know who to go to if they have concerns. However, the effort that agencies devote to seeking children's views is variable and often depends on the continuity of staff, which is undermined in services with a high staff turnover.

'[It's helpful] having a social worker who listens to my views…knowing I will be listened to…the social worker listening and helping me talk with my daddy.' [ref.15 http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf*]*

'I know who to talk to if I have a problem.' (Hearing-impaired child in a primary school)

'There is always someone to talk to – it may be a favourite teacher but the learning mentors are always there for you.' (Secondary school pupil with a hearing impairment)

4.8. The provision of child-friendly complaints systems still varies. This is reflected in survey results[7] about social services' complaints systems: 66% (401) of children who responded knew how to make a complaint, but 26% (161) did not. Some acute hospitals do not have complaints leaflets specifically aimed at children and young people. There is also evidence that direct access by children and young people to Patient Advice and Liaison Service (PALS) advocates is inconsistent. NHS staff sometimes act as advocates for children but this could lead to conflicts of interest. Many independent hospitals that treat small numbers of children do not have child-friendly complaints systems.

INVOLVING AND INFORMING CHILDREN AND YOUNG PEOPLE

[6] Social Services Inspectorate (Commission for Social Care Inspection from 1st April 2004) questionnaire surveys of children over 8 years of age, 2003-04.
[7] Social Services Inspectorate questionnaire surveys of children over 8 years of age, 2003-04.

4.9. Work by social services to help children to protect themselves, for example against substance misuse, self-harming or domestic violence, is mainly focused on older children and young people. There are examples of targeted work with families with adolescents at risk of family breakdown helping to reduce the numbers of looked after children. This work is in place in some councils but not in others. In special education establishments and mainstream schools, personal, social and health education (PSHE) covers issues such as bullying, self-harming, drug awareness, sex education and personal safety. This area of the curriculum is an essential part of preparing children and young people to protect themselves from harm and abuse and is especially important for vulnerable children with disabilities. Even when PSHE is well taught, there is not always enough emphasis on harm from people known to children.

Good practice

Innes School in Rochdale is an all age school for pupils with severe, profound and multiple learning difficulties. The school's PSHE programme includes relevant modules about keeping safe, using schemes of work and supporting materials specifically designed for pupils with learning disabilities. For example, specific lessons focus on giving pupils the knowledge and confidence to speak or communicate to a range of adults if they have worries.

[Ofsted/CSCI]

4.10. The provision of information about services to children and parents presents a variable picture. For example, where social services have a good range of information, it is in languages and formats suitable for children who access the service, including websites. Where information is less satisfactory, common factors are that it is out of date, inadequate or incomplete and not targeted to children. Some Local Education Authorities (LEAs) have made good progress in using web sites and information leaflets to provide more comprehensive information about services and support for pupils and parents.

Good practice

At Dudley College of Technology, there is a wide range of help for personal, financial, domestic, childcare, transport and health problems that prevent students from staying in education. Child protection measures have been in place for over six years. Student diaries given at induction clearly outline the protection all students, including those over 18, can expect.

[Ofsted]

4.11. Agencies recognise that they should pay attention to a child's ethnic, cultural, religious and language needs. In practice, they are still not taken sufficiently into account across all settings. Councils usually have a range of policies and generally try to take account of diversity issues. However, only one third of councils believe that they consistently communicate effectively with children whose preferred language is not English or who use non-verbal forms of

communication [*Ref. 52* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4076335&chk=sYTWwQ].

4.12. Police forces are now paying close attention to diversity across most areas of activity. However, diversity is not as clearly or as well integrated into child protection policies and procedures as those relating to adult victims of crime. Specialist interpreters who are skilled at working specifically with children are rarely available. Most NHS trusts have access to some form of interpreting service. In practice, however, there can be difficulties or delays in locating specific interpreters, for example for children who require interpretation to be in an alternative medium such as sign language. Also, expertise in communicating with children with disabilities is still inadequate, so that those with general and specific communication difficulties are disadvantaged.

4.13. Some services do not keep children and parents sufficiently informed about and involved in matters of concern to them. In some social services departments, parents are not always clear about what needs to happen for their child's name to be removed from the child protection register[8]. In addition, for children placed for adoption, there is not always sufficient emphasis given to the child's perspective. Health services have improved significantly in explaining treatments and care plans for children. Most special education establishments give good feedback to parents or carers about their child's educational progress but they provide little information specifically about safeguards or child protection procedures.

MAKING SAFEGUARDING A PRIORITY

4.14. All agencies that have direct involvement with children need to see the safeguarding and welfare of children as one of their major priorities. This is reinforced by the Children Act 2004, which places a specific duty on them to ensure that they take account of the need to safeguard and promote the welfare of children in their work [*ref.3* http://www.dfes.gov.uk/publications/childrenactreport/ -2004]. The children's National Service Framework has also helped to raise awareness in both the NHS and the independent health sector. Across agencies, there is evidence of significant improvement in the priority given to safeguarding since 2002. Policies and procedures are more child-centred and there is a greater acknowledgement at senior levels of the need to promote safeguarding.

4.15. Mainstream state schools have improved considerably since 2000 in complying with the statutory responsibility for child protection of pupils in schools, although this is more variable in the secondary sector than in the primary sector. Many schools have effective policies for reducing oppressive behaviour. This

[8] A central register maintained by each social services department, listing all the children resident in the area who are considered to be at continuing risk of significant harm and for whom there is a child protection plan.

corresponds with those schools that have a high incidence of free school meals (an indicator of higher deprivation). 91% (72) of LEAs inspected have policies for health and safety and child protection that are satisfactory or better. Nonetheless, these policies and procedures are not consistently adapted to take account of the needs of children and young people with communication, sensory or learning disabilities.

4.16. Nearly all NHS trusts now have a person with responsibility for child protection at board level. Most trusts also have named and designated health professionals in post. This has significantly raised the profile and status of child protection issues. Some types of trust show considerable improvement. For example, in 2003, only 60% (18) of ambulance trusts had a board level child protection lead, whereas in 2004 all ambulance trusts had one. However, not all NHS boards receive an annual report on child protection. For example, 82% (141) of acute trusts and 90% (272) of primary care trusts receive such a report, but only 53% (16) of ambulance trusts do [*refs.15,16*]. Independent health providers have also improved in the extent to which they have developed these recommended safeguarding features, following increased focus on this area by inspectors.

Good practice

South London and Maudsley NHS Trust, which specialises in mental health services, has significantly raised the profile of safeguarding. Initiatives include: a board level lead and dedicated child protection staff; a comprehensive audit of the implementation of recommendations from serious case reviews; a CAMHS risk management committee, which considers complaints, serious incidents and serious case review recommendations; and mandatory child protection training programmes. An audit of pregnant women and those with young children using mental health services was a joint initiative with Southwark social services and considered safeguarding issues, reflecting a key ACPC priority.

[Healthcare Commission/CSCI]

4.17. All but one of the 43 police forces have clear child protection procedures and guidance. However, child protection is not a priority in 41% (18) of policing plans, mainly because there is a lack of focus on children's safeguards at a national level. Child protection is not a national priority area or currently monitored by means of a national performance indicator.

4.18. The safeguarding needs of some specific groups of children and young people are not given sufficient priority. For example:

- The provision of services for young people aged 16-18 is often inconsistent and there is often a gap between children's and adults' services. This is especially so for young people with chronic illness or disability and in Child and Adolescent Mental Health Services (CAMHS), although the Department of Health Public Service Agreement requires

that, by December 2006, all PCTs should commission a comprehensive CAMH service for children up to their 18th birthday. To address the gap in provision, many paediatric specialists continue to see young people over 18 in some NHS trusts, particularly where there is no adult specialist for a particular condition. Also, some trusts have set up joint clinics with adult services and have protocols on how to address transition services;

- Continuing capacity problems in both NHS and independent sector CAMHS services often result in children being cared for in adult wards. A survey during 1999-2001 found that almost two thirds of young people under 18 needing in-patient psychiatric care were admitted to adult wards. The Mental Health Act Commission have regularly voiced their concerns about the treatment of children within adult mental health services [*ref.59* http://www.mhac.org.uk/]. Children in such environments have limited access to advocacy, education or age-appropriate activities;

- There is sometimes a failure to recognise child protection concerns for children placed for adoption;

- Our inspection evidence shows that some councils have placed children on care orders at home with their parents without following regulations[9] or sufficiently monitoring them. Returning children to parents could sometimes be seen as a way of reducing out-of-area placements, rather than ensuring the needs of the children are paramount;

- Secondary and special schools are less compliant with safeguards requirements than primary schools and nursery schools. Also, in special schools, policies such as those for preventing bullying are not always adapted to the specific needs of children with disabilities; and

- Safeguards for children with disabilities are not always given a high priority in all social services, although there is now a greater acknowledgement of child protection issues than in the past. There are, however, some examples of good practice in catering specifically for the needs of children with disabilities.

[9] The Placement of Children with Parents Regulations, 1991.

Good practice

In Norfolk County Council, three specialist teams across the county provide services for children with disabilities covering the full range of functions, including child protection and support to looked after children. There is a high level of joint working across agencies with individual children and multi-disciplinary assessments. The independent organisation Triangle has run courses on direct communication and child protection with children with disabilities, reaching around 100 staff.

[CSCI]

ASSURING SAFEGUARDING IN PRACTICE

4.19. Safeguarding policies need to be supported by robust arrangements for audit and monitoring and systems for feeding back the learning into service improvement for children. This remains an area for development in all services. Particular concerns arise across agencies about whether policies and procedures for safeguarding are put into practice or apply uniformly throughout organisations. For example, the NHS audits carried out in 2003 show that the vast majority of NHS organisations have child protection procedures, but there were some doubts in these audits about whether they were put into practice throughout the organisation. Some NHS organisations were also concerned that areas outside dedicated children's areas are not child-friendly or that not all staff respond fully to individual children's non-medical needs [*ref.15* http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf]. Inspections in the independent sector have found a similar situation.

4.20. In social services, auditing of practice now happens more often but presents a mixed picture. For example, most councils are able to evaluate how extensively black and minority ethnic communities take up services, but councils are at different stages of development in adapting their services and systems in response [*Ref.52* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4076335&chk=sYTWwQ]. In police forces, limited auditing takes place within child protection and there is an over-reliance on supervision to ensure that standards are met. Management information collected is primarily quantitative and gives little indication of the performance of Child Abuse Investigation Units, nor is it always being used to inform improvement. In the NHS, audits in 2003 found that monitoring of compliance with standards was inconsistent. Monitoring of independent contractors[10] by primary care trusts was particularly variable, but in 2004 only 62% (188) of primary care trusts were monitoring the implementation of child protection arrangements in GP practices [*ref.16* http://www.healthcarecommission.org.uk/InformationForServiceProviders/PerformanceRatings/fs/en].

[10] Including general practitioners (GPs), dentists, optometrists and pharmacists.

Good practice

The Vale Resource Base, Haringey, is an all age school for pupils with physical disabilities. The designated teacher for child protection regularly reviews and monitors the records kept. A designated subcommittee of the governing body, monitors policies and procedures relating to safeguarding and ensures that they are accessible to pupils.

[Ofsted/CSCI]

RECOGNISING AND ACTING ON WELFARE CONCERNS

4.21. Ensuring welfare concerns are promptly identified and acted upon is fundamental to safeguarding. Awareness of potential welfare concerns has improved both within and between agencies. For example, frontline police officers outside child abuse investigation units are aware of the need to identify and report child protection concerns when attending incidents such as those involving domestic violence. There is also evidence that the use of the *Framework for the Assessment of Children in Need and their Families* [*ref.17* http://www.archive.official-documents.co.uk/document/doh/facn/fw-00.htm] is improving and that good inter-agency working has contributed to improvement.

4.22. Other evidence shows that there is a mixed picture. Numbers of children on the child protection register remained almost static during 2002-04, but this masks wide variations between councils. Where there has been a reduction in numbers, this may reflect increased levels of trust between social services, education, health and youth justice services as well as better engagement from parents. However, this could also reflect some social services' views on how to demonstrate improved performance. Allied to concerns, considered below, about how referral thresholds are being applied, there is a risk that some children in need[11] could be falling through the safeguarding net.

4.23. Most concerning of all, evidence from a wide range of sources indicates that there are continuing problems in two key areas: recognising or acting on welfare concerns; and inappropriately high referral thresholds in many social services departments. It is of concern that these were also findings from the first *Safeguarding Children* report and the post-Victoria Climbié Inquiry audits [*refs.15* http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf*, 18* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4004257&chk=gQ%2BFkF]. It means some children continue be at risk and are not receiving an adequate response to their needs. These issues are considered in detail below.

4.24. First, not all agencies ensure that staff know how to recognise the signs of abuse or neglect and how to act on them. Furthermore, it is not always easy for staff to gain access to relevant information or advice about welfare concerns to

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[11] As defined under section 17 of the Children Act 1989.

inform decisions about what action to take. This has serious implications for certain groups of children. Pre-school children are a particularly vulnerable group. Overall, providers are unsatisfactory in less than 1% of childcare inspections. However 3% of those inspected during 2003/04 (nearly 28,000) had difficulty in demonstrating that they can meet the required standard of knowledge for recognising and reporting child protection concerns. Most of the 542 childminders who failed to meet this standard did so because they were unsure how to report concerns. The 279 day care providers who failed to meet the standard usually did not have effective procedures for staff to follow when they needed to report concerns. In some NHS trusts, identifying welfare concern is compounded by difficulties in accessing previous case notes or the child protection register, and by some poor record keeping and auditing. Many trusts are now undertaking audits of records and access to the child protection register has improved since 2003, but it is still not comprehensive.

Good practice

At St Mary's, part of Central Manchester and Manchester Children's University Hospital NHS Trust, if a midwife identifies child protection issues or other concerns, they are discussed with the family, the line manager and, if necessary, another midwife. These discussions are documented on a special form, which includes an action plan and is filed in the notes. A copy is sent to the named midwife, who keeps it in a central file. If a referral is made to another organisation, an agency referral form is completed and filed in the mother's notes and its contents discussed with the family.

[Healthcare Commission/CSCI]

4.25. Recognising child protection issues for children with disabilities raises particular concerns. In some areas, these children are under-represented on the child protection register. This may be because any marks or injuries are not always recognised as possible abuse, practitioners may be reluctant to suspect abuse, or because of communication difficulties between a practitioner and a child. Special schools generally make child protection referrals appropriately. However, staff are not always good at identifying and tracking behaviour patterns and trends, whether the behaviour shows itself as overt challenge or emotional withdrawal. These can be indicators of child protection concerns.

Good practice

At Sweyne Park, a secondary school for pupils with hearing impairment, staff are routinely expected to monitor and record pupils' attitudes, learning and behaviour. Any welfare concerns arising are recorded on incident forms, which are regularly checked by heads of year with the designated teacher for child protection.

[Ofsted]

4.26. Between 2002 and 2005, there were few serious case reviews[12] of children with disabilities reported. However, there is evidence that the recording and notification of incidents and serious case reviews are inconsistent and there is uncertainty about the precise numbers of serious case reviews carried out. This is compounded by confusion in some NHS trusts about when it is necessary to hold a serious case review or when an internal management review of a critical incident is appropriate.

4.27. Social services report that agencies do not always understand thresholds for referrals, sometimes delay making referrals and are unclear to whom they should refer. Referrals are still not always followed up in writing, despite the recommendation of the Victoria Climbié Inquiry, and the requirement to do so in the widely distributed document '*What to do if you're worried a child is being abused* [*Ref 61* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010283&chk=YpgIw9]. Similarly, police forces indicate that there are delays in social services and NHS staff notifying them of concerns that may affect criminal investigations. There is little evidence of joint auditing between the police and social services to ensure that referrals are made appropriately and promptly.

Good practice

Bolton Metropolitan Borough Council developed the Bolton Child Concern Model, which set out graduated levels of vulnerability on a continuum of child concern. The model helped all agencies working with children to achieve a shared understanding about the thresholds for intervention. It also enabled children and families to access services without the need for unnecessary referral to child protection services. The model was later adapted to work within the Identification, Referral and Tracking (subsequently Information Sharing and Assessment) model, for which Bolton was a trailblazer council.

[CSCI]

4.28. Secondly, many agencies report that thresholds for referrals are too high in some social services departments, which are prioritising child protection but not responding appropriately to all children in need. Agencies also report that the response from social services is sometimes slow and there is a lack of feedback about outcomes. This view reflects a complicated picture. Social services may be dealing with priorities as far as resources allow, rather than meeting specific levels of need. Staff shortages and workload pressures also combine to raise thresholds in practice. Also, there are sometimes unrealistic expectations by

[12] A review carried out under Chapter 8 of *Working together to safeguard children [ref. 22]*. When a child dies or suffers a serious injury, and abuse or neglect are suspected to be a factor, the Area Child Protection Committee is required to carry out a review of the involvement of agencies and professionals.

other agencies of the role and responsibilities of social services.

4.29. Since many council social services are unable to respond sufficiently to families needing support, other agencies do not always refer children when concerns about their welfare first emerge. Some families are therefore likely to be subject to avoidable pressure and children may experience preventable abuse or neglect. Relationships between social services and other agencies are also placed under considerable pressure. The *Every Child Matters* agenda has been developed partly to address these concerns. In particular, the Common Assessment Framework is being developed to support earlier assessment and intervention from a range of agencies, so that only appropriate referrals are made to social services [*ref. 55* http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1310]. Some councils are already working effectively with partner agencies to enable children and families to access services without the need for unnecessary referrals to child protection services. However, given the current pressures in the system, local councils and their partners will need to review their capacity to deliver and to overcome the long-standing concerns about inappropriately high social services thresholds.

4.30 As the local change programme develops and local children's trusts are established, care will need to be taken to clarify accountability arrangements and responsibility for forward planning between the Local Safeguarding Children's Boards and the children's trust governance arrangements. Particular attention will need to be given to ensuring that thresholds for specialist services are consistent with ensuring that children are safeguarded effectively. Children and Young People's Plans, which must be in place for April 2006, will need to reflect priorities for safeguarding as well as for universal and preventive services.

4.31 Special schools report particular concerns about children and families in need of support and indicate there is a better response from social services to child protection enquiries[13]. They also express concerns about social workers' understanding of disabilities and special educational needs. This sometimes applies to social workers in specialist teams for children with disabilities. Inspections also raise concerns that social services are not sufficiently identifying child protection or welfare issues for children placed for adoption. There also appears to be more complacency in dealing with allegations about prospective and approved adopters and some examples where concerns have not been followed up sufficiently.

Good practice

In Richmond-upon-Thames, the Disabled Children's Team is developing its role to ensure that children are safeguarded and protected. Initiatives include: a protocol with the Initial Response Team about joint visits to new referrals where

[13] Under section 47 of the Children Act 1989.

responsibility is not yet clear; specialist training, including training in abuse materials to assist communication with children with disabilities; specialised counselling for children with disabilities; and vetting, training and support for staff, carers and volunteers.

[CSCI]

WORKING TOGETHER TO SAFEGUARD CHILDREN AND YOUNG PEOPLE

4.32 All the evidence indicates that children are safeguarded best where there is clarity and understanding between different agencies about roles and responsibilities, underpinned by good working relationships at all levels. There are examples of good joint working, for example between police child abuse investigation units and children's teams in social services and between social services and health, especially where there are on-site social workers in hospitals. This is one of the good practice markers in the children's National Service Framework. Some trusts have regular multi-agency team meetings involving social workers to ensure that concerns and care plans about a child are appropriately shared. Also, schools for pupils with disabilities report examples of good joint agency training and the benefits of shared understanding of roles and responsibilities across agencies.

4.33 However, good multi-agency working sometimes depends on personalities in the absence of robust protocols and procedures and it is not uniformly satisfactory. For example, there is sometimes a lack of clarity between the police and social services about the status of investigations and the criteria for deciding whether an investigation will be single or joint. Similarly, the police role in strategy discussions and case review conferences is not always well defined. Comprehensive new guidance from the Association of Chief Police Officers (ACPO) on child abuse investigations will clarify the role of the police [*ref.19* http://www.acpo.police.uk/asp/policies/Data/Child%20Abuse%20-%20ACPO%20guidelines.pdf].

Good practice

In Durham Constabulary, a formal meeting takes place between the Vulnerability Unit Sergeant and social services team manager a few days after the strategy discussion. The aim is to identify whether all the actions agreed at the previous meeting have been carried out and to consider any further action necessary to progress the investigation. The results of the meeting are formally recorded and a copy is kept on the case file.

[HMIC]

4.34 Other findings include:

- There is a lack of clarity between agencies about what information can be shared or a reluctance to share it. Cross-government guidance for practitioners on appropriate and lawful sharing of information is being produced;

- Child protection core groups are not always working well. Their purpose is not always appreciated by agencies other than social services, resulting in poor attendance and delay in agreeing the Child Protection Plan and the necessary steps to improve the family situation; and

- There are very variable relationships and poor communication between schools and social services compounded by LEAs and social services departments failing to devise strategies to address poor working relationships. This should be addressed within the *Every Child Matters* agenda, and in the development of integrated children's services, with a specific responsibility on senior managers to ensure that there are effective working relationships within and between agencies.

Good practice

Leeds Teaching Hospitals NHS Trust has clear information sharing protocols with the police and social services. Social workers can access and write notes on medical records.

[Healthcare Commission/CSCI]

4.35 At a strategic level, Area Child Protection Committees (ACPCs) currently exist to bring together in a council area the agencies and professionals responsible for helping to protect children from abuse and neglect. They will be superseded in 2006 by Local Safeguarding Children Boards (LSCBs), statutory bodies whose detailed role and remit will be subject to consultation in 2005. Inspection findings raise a number of issues for consideration in the development of LSCBs.

4.36 The effectiveness of ACPCs has improved since the first *Safeguarding Children* report and much effort has been put into revising and updating ACPC procedures. However, there is still considerable variation in the extent to which they provide active and effective leadership. This is affected by representation that is not always at the right level, lack of involvement or representation of some important groups (GPs are particularly difficult to engage) and inconsistent attendance.

4.37 There is also evidence that serious case reviews do not always fulfil their function. They are intended to bring together the results of management reviews carried out by individual agencies to identify and share the lessons from cases about working together. However, there is confusion in some agencies about the definition and recording of serious case reviews (see paragraph 4.26), frequent

delays in completing them and reports that recommendations are not always sufficiently specific or realistic. Furthermore, the lessons do not always reach all relevant professionals, especially front-line staff, and concurrent criminal proceedings can delay feedback. Several councils have run multi-agency workshops on lessons to be learned from Serious Case Reviews and have provided related training, such as working with hostile families.

ENSURING SAFE ADULTS WORK WITH CHILDREN AND YOUNG PEOPLE

Recruitment

4.38 Some services are under considerable pressure because of difficulties in recruiting and retaining suitably qualified and experienced staff, especially in social services in London and the south east. The resulting high workloads for individual managers and staff contribute to delays in responding to referrals and allocating cases and to tensions between agencies, often to the detriment of individual children. Councils are adopting a range of strategies for improving recruitment and retention, but some of them will take time to work through in practice. They include:

- offering a rolling programme of trainee schemes, which combine work with access to accredited courses as part of a ‘home-grown’ approach. This route into social work has proved very popular;

- identifying competencies required for the range of tasks to be delivered, and creating differentiated posts requiring skills or qualifications other than those traditional to social work;

- establishing partnerships for recruitment with other organisations, such as health services;

- recruiting staff from outside the UK;

- establishing structured career pathways for people entering the social care profession;

- offering a competitive salary structure and other financial benefits such as loyalty payments. However, this approach to remuneration needs to be cautiously applied to avoid inflating the market and increasing staff instability;

- responding to staff concerns to improve staff retention. This has led to a range of approaches, including: providing access to a range of accredited post-qualification courses; giving financial recognition for increased expertise; ensuring staff are well-supported in carrying out their work; encouraging staff to contribute to improving services; and offering flexible, family-friendly, working patterns and benefits;

- encouraging agency staff to apply for permanent posts by offering the range of benefits described above; and

- adopting a creative approach to recruitment, including: attractive marketing campaigns giving the council a distinctive identity; rolling recruitment through the council web-site; and a continuous focus on maintaining high levels of staff in post.

4.39 The Children's Workforce Strategy will take forward these initiatives, among others, such as the development of a single qualifications framework for the children's workforce, and development of local workforce strategies, as part of an overarching strategy to deliver the objectives of the *Every Child Matters* agenda [*Ref.55* http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1310].

4.40 The status of work in the area of child protection has improved in some services. HMIC's review of child protection in 1999 found that staff working in specialist child protection teams in police forces felt undervalued [*ref.20* http://www.homeoffice.gov.uk/hmic/childpro.htm]. Since then, there has been a significant change in understanding and perception of the role of Child Abuse Investigation Units among police officers. The requirement for unit staff to undertake the Initial Crime Investigators Development Programme is specifically highlighted as having had a positive impact on perceptions. This has contributed to a greater understanding of child protection issues throughout forces and a growing awareness of child protection as a frontline policing issue.

Safeguarding checks on staff

4.41 Following the Soham murders, Sir Michael Bichard's Inquiry made a range of recommendations on information management and sharing, and staff vetting [*ref.21* http://www.dfes.gov.uk/childrenandfamilies/bichardimplementation/pdfs/bichardreport.pdf]. At the time of this review, the government was consulting on a proposed centralised vetting and barring scheme for people working with children and vulnerable adults [*ref.57* http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1317]. This would extend the scope of existing compulsory checks to a wider range of employees and volunteers. It would also assist the detection of people already working with children and vulnerable adults who become unsuitable, so that they can be prevented from continuing in this work. The proposals, if accompanied by more rigorous and quality-assured recruitment processes introduced by employers, would strengthen the system and address some of the concerns raised in this report.

4.42 However, it will take some time to implement fully the Bichard recommendations in relation to staff vetting. In the interim, recruitment practices continue to raise considerable concerns. Arrangements are generally in place

throughout services to check the background of all staff recruited on a permanent basis. However, there are some concerning variations, especially in respect of staff who move to a different job with the same organisation, staff in post for many years who have not been rechecked (especially in residential schools) and temporary staff and voluntary workers. Some services, notably the NHS, also report continuing difficulties in the timely processing of checks by the Criminal Records Bureau (CRB). These are recurring themes throughout this report.

4.43 In social services, policies and procedures on recruitment and vetting generally exist. Despite this, there is inconsistent checking of staff in unsupervised contact with children. For example, two separate references for new employees are not always on file and qualifications are not always checked. Common problems include no evidence of CRB checks, gaps in employment history and no evidence of qualifications. A central record of agency staff is not always kept, or references verified, so that unsatisfactory agency staff can move from one council to another.

4.44 In the mainstream state schools inspected, the overall position in relation to staff checking is satisfactory. However, in independent schools, 24% (23) of the 96 schools inspected did not comply with appropriate staff checks and this is a serious cause for concern. In special education establishments, checking of staff is done for permanent staff but is less rigorous for contractors. For the seven LEAs judged unsatisfactory, a common feature was inconsistency of enhanced CRB checks on adults in contact with children.

4.45 In NHS organisations, audits in 2003 found that CRB checks were carried out for permanent staff, but rechecking was inconsistent [*ref.15* http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf]. The checking of temporary staff and volunteers was not always done as a matter of course. Not all NHS organisations had a specific person with responsibility for ensuring that checks are made with the CRB, although in 2004 all types of NHS organisations had improved in this area [*ref.16* http://www.healthcarecommission.org.uk/InformationForServiceProviders/PerformanceRatings/fs/en]. Some trusts are now rechecking staff when they move within the organisation.

4.46 There is also concern about the vetting of the increasing numbers of staff coming from outside the UK to work in public services, particularly in the NHS. The CRB is unable to perform checks outside UK jurisdiction and staff have to be checked on any information that has been brought to the attention of the professional associations or prospective employers by employees themselves. This issue was the subject of a recommendation by the Bichard inquiry. Although there are a number of initiatives in progress to improve cross-border co-operation, this matter requires urgent attention.

4.47 In police forces, all staff are subject to vetting on appointment but further checking on appointment to Child Abuse Investigation Units is not routinely

carried out. However, new ACPO guidance on child abuse investigations addresses this by stating that staff working in these units should be subject to a particularly high level of vetting and that this process should be described in any advertisements for posts [*ref.19* http://www.acpo.police.uk/asp/policies/Data/Child%20Abuse%20-%20ACPO%20guidelines.pdf].

Training and skills

4.48 Agencies acknowledge that regular supervision of staff is highly important in safeguarding children, but its frequency and quality vary. This is often affected by high workloads carried by first-line managers. For example, not all NHS trusts have named doctors and nurses and many do not currently provide protected time to carry out the role. In providing data for the child protection performance indicator in 2004, a number of trusts said they were addressing the issue of protected time. Several also commented that guidance about the roles and functions of named and designated staff is not clear and needs updating.

4.49 ACPCs provide basic awareness training in child protection that complements induction training provided by individual services. Well co-ordinated cross-agency training is also an important feature of effective safeguarding arrangements. LEAs and social services departments jointly organise and run training on child protection for designated teachers and for school governors. From September 2003 to March 2005, of the 45 LEAs inspected, 89% (40) were judged satisfactory or better for training in child protection and health and safety.

4.50 There are also some good examples of specialist training. Many NHS trusts have set up models for three levels of safeguarding training. Level one, normally mandatory, is an introduction to safeguarding children to all staff. Level two is more detailed and extensive and includes, for example, recognising signs and symptoms, referral procedures and roles and responsibilities of different agencies. Level three includes children with disabilities, annual updates, learning from serious case reviews and specialist subjects such as forensic medical examination. Most programmes have been favourably evaluated.

4.51 However, there are some common shortcomings in training provision, which include:

- lack of training in safeguards issues for staff outside specialist teams in social services, for example: in adoption teams; disabled children's teams; and teams working with adults with learning difficulties or mental health problems;

- staff in a range of settings not consistently trained in child protection and safeguarding to meet the needs of children with disabilities;

- gaps in specialist training for Child Abuse Investigators in police forces (to be addressed by ACPO-commissioned training) and for designated teachers in some schools;

- poor staff participation in both child protection and behaviour management training in schools where compliance with child protection is less satisfactory. There is also low participation by GPs in training provided by primary care trusts. This was a finding in the first *Safeguarding Children* report, although there has been some improvement since 2002;

- variable training in special education establishments for staff other than designated staff, although staff generally receive written guidance about issues such as physical contact; and

- under-provision of up to date training for council staff on race, cultural and equalities issues. Many council staff say they lack confidence in working with families from different backgrounds [*ref.52* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4076335&chk=sYTWwQ].

CONCLUSIONS

4.52 There has been considerable progress since 2002 in the extent to which agencies give priority to safeguarding children who live at home. This is illustrated by greater effort devoted to listening to and consulting with children, increased commitment at senior levels to safeguarding and more extensive inclusion of safeguarding in policies and procedures. Many agencies are now working together better, assisted by greater clarity about respective roles and responsibilities, and have put effort into improving working relationships. Also, there are many skilled and committed staff working with children and young people.

4.53 However, children are not uniformly receiving the care and protection they need and there are a number of key areas for improvement. Some of the issues will be addressed through the development of the *Every Child Matters* agenda, and agencies need to continue to build on the good work carried out since 2002. Areas for improvement include:

- monitoring how extensively the safeguarding ethos spreads throughout organisations;

- giving priority to the safeguarding needs of children with disabilities; children aged 16-18 with a mental health condition or a chronic illness; and children placed for adoption;

- giving greater consideration to the complexity of working with children with language and communication difficulties;

- clarifying for staff how to recognise and report the signs of abuse or neglect;

- clarifying thresholds in social services to ensure that all children in need receive an adequate response;

- improving relationships and communication between some agencies, for example between education and social services and NHS trusts and social services, especially where social services thresholds are perceived to be high. These need to be jointly addressed by the agencies concerned through the *Every Child Matters: Change for Children* agenda;

- addressing the variation in the membership and effectiveness of ACPCs in consulting on and establishing Local Safeguarding Children Boards; and

- ensuring consistent recruitment and checking procedures for new and existing staff and contractors who are in contact with children.

5. CHILDREN LIVING AWAY FROM HOME

INTRODUCTION

5.1. Many children are cared for in settings away from home. They need special attention to ensure that they are adequately safeguarded. Sir William Utting's report in 1997 *People Like Us* provided an influential and much-needed focus on children living away from home.[14] Research suggests much has been done since the Utting report to improve safeguards for these children. They are now less marginalised than before, but the needs of some particularly vulnerable children still need to be addressed [*refs.24*http://www.jrf.org.uk/bookshop/details.asp?pubID=642, *and 25* http://www.jrf.org.uk/bookshop/details.asp?pubID=642].

5.2. Following the first *Safeguarding Children* report, inspection work has paid particular attention to children who live away from home. This chapter looks at how well agencies plan and deliver safeguards for children in a range of settings. In addition to inspection work, the findings are informed by the consultations of children looked after and in residential education carried out by the Children's Rights Director[15].

SETTINGS WHERE CHILDREN ARE CARED FOR

5.3. This report includes the following groups of children:

- **Children looked after in children's homes and foster care**: there are around 5,900 children in regulated children's homes. Around 41,600 children are in foster care. A further 3,300 children are placed for adoption. A special review looked at arrangements in five councils for meeting the needs of children who live outside their home area and tracked children to a further 10 councils. This chapter also draws on evidence from CSCI inspections of children and family social care services and regulatory inspections of foster care and children's homes[16].

- **Children in boarding schools**: there are 555 boarding schools in England. This chapter draws on evidence from National Care Standards Commission (NCSC), and subsequently CSCI, inspections of welfare arrangements in all local authority maintained and independent boarding schools and on Ofsted's inspections in maintained schools, which look at

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[14] Utting, W. et al, *People Like Us – The Report of the Review of Safeguards of Children Living Away from Home,* The Stationery Office, 1997

[15] The Children's Rights Director, based within CSCI, has an independent statutory role in safeguarding and promoting the rights and welfare of children.

[16] Until 1st April 2004, inspection of social care services was carried out by the Social Services Inspectorate and regulation of care settings by the National Care Standards Commission. The Commission for Social Care Inspection took over this work in 2004.

educational arrangements. Reference in this chapter to 'boarding schools' refers to the evidence drawn from NCSC/CSCI's welfare inspections in these schools.

- **Children in residential special schools and colleges**: there are around 6,500 places in 242 residential special schools in England. This chapter draws on a review of provision for children in three special schools with residential facilities and two independent residential specialist colleges (for students with disabilities aged 16 and over) and on mainstream inspection work.

- **Children who spend long periods in hospital**: of the 1.8 million children who left hospital between April 2003 and March 2004, only 3,300 (0.2%) had spent more than 3 months there. Nonetheless, these children have acute, complex or chronic illnesses or a mental health condition and are particularly vulnerable. A special review looked at six NHS trusts in England, which are mainly specialist centres for children and young people with complex needs. The review included children with a chronic illness who visit hospital regularly as outpatients, experience frequent hospital stays over long periods or have received specialist treatment for many years in the same hospital.

  Some children and young people are also treated in independent hospitals. The services provided for those who stay more than three months normally include specialist eating disorder services, psychiatric intensive care and secure services. The placements are invariably out of area. This means that most of these children are cared for a long way from home and they become detached from local services until the provider discharges them. The monitoring of these placements by the referring authorities and commissioning PCTs is variable.

- **Children in secure children's homes and secure training centres**: secure children's homes[17] cater for around 388 children who are looked after under the welfare provisions of the Children Act 1989 or who are remanded or sentenced under criminal legislation. Four secure training centres provide secure accommodation for 280 children and young people who are remanded by courts in the process of criminal proceedings or who have been sentenced following conviction. This chapter draws on inspection evidence from eight secure children's homes and one secure training centre.

- **Children and young people in young offender institutions:** 12 establishments hold boys aged 15 to 18 and four hold girls in the same age group. In January 2005, there were 2,152 boys and 53 girls in young offender institutions (535 remanded in custody and 1670 sentenced). In

[17] Formerly known as local authority secure units.

2002, a landmark judgment in an action brought by the Howard League ruled that children in prison are owed the same duties by local authorities under children and human rights legislation as if they were living in the community, subject to the requirements of imprisonment [*ref.26* http://www.lawreports.co.uk/qbnovc0.3.htm].

5.4. Children who are in private fostering may not be identified or adequately safeguarded, and this has long been of concern. The government is bringing in replacement regulations and guidance in relation to private fostering in July 2005, and new National Minimum Standards will be introduced. These aim to strengthen the existing notification scheme and provide additional safeguards for privately fostered children. They will require local councils to take a more proactive approach to identifying private fostering arrangements in their area. The greater focus on this area is welcome but it is not yet clear how effective the recent legislation and new guidance will be. Future inspection activity will need to focus on assessing safeguarding in this area to determine if the implementation of a full registration system for private foster carers, as provided within the legislation, should be recommended.

5.5. In addition, children live away from home in many unregulated settings. There are some residential education and training arrangements which are not subject to any form of statutory regulation since they do not accommodate and care for children away from home for more than the 27 day threshold that usually triggers a requirement to register and be regulated. There are also many specialist educational, sporting and recreational provisions that look after children by day away from home, which are not currently subject to regulation (unless attended by children under eight), where safeguarding issues are also critical. These include language tuition for foreign nationals and sports, drama and music provision.

5.6. Some of these providers are governed by a national body, such as the England and Wales Cricket Board, which has drawn up strict protocols on safeguarding and child protection, in partnership with the NSPCC, to which all members must subscribe. In order to run junior teams, affiliated members must complete a CRB check on adults involved with children, appoint a Child Welfare Officer, attend child protection courses and develop links with local ACPCs. The situation is much less clear in some of the other settings, particularly on such basic issues as whether staff looking after or instructing children are subject to CRB checks. However, there is encouraging evidence of a significant increase in child protection policies being developed by many of the bodies affiliated to the Arts Council, the Sports Council, various church organisations and community and volunteering groups. Safeguarding children would be greatly advanced by the adoption and implementation of CRB checks and child protection policies and procedures for all organisations looking after children away from home, either by day or residentially, even for short periods of time. The government proposals in response to the recommendations of the Bichard Inquiry will be addressing these

issues. *{Ref 57* http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1317}

5.7. Recent reports by the House of Commons Defence Committee and the Adult Learning Inspectorate also indicate that there are significant deficiencies in the safeguarding arrangements for young people of 16+ who are recruits in training in the armed services [*refs.53* http://www.publications.parliament.uk/pa/cm200405/cmselect/cmdfence/63/6302.htm *, and 54* http://docs.ali.gov.uk/MOD_files/PDFreports/h_shortreport.pdf]. Although these reports made wide-ranging recommendations, none specifically relate to child protection and the engagement of ACPCs. Welfare inspections focusing especially on the safety, protection and welfare of young people under 18 in armed services recruitment establishments could, with slight modifications, be established against the existing National Minimum Standards for residential provision for under 18s in Further Education Colleges. This would help to focus on the vulnerability of these young people and their particular needs for safeguarding and protection. In addition, the Howard League judgment established that social services responsibilities should apply to children in prison establishments. Clarification would be helpful on whether this should by extension apply to those under 18 in armed forces training and other establishments. Following specific recommendations made by HM Inspectorate of Prisons during inspection of armed services' detention facilities, child protection procedures have been put in place and implemented[18].

PROMOTING CHILDREN'S RIGHTS AND SAFETY

5.8. Children living away from home identify a wide range of risks to their safety, including bullying, accidents, illness and abuse [*ref.6* http://www.csci.org.uk/publications/childrens_rights_director_reports/safe_from_harm_report.pdf].

> *'Cars, roads, terrorists, kidnappers, people giving you drugs, getting left behind, bullying, food poisoning, drowning, other accidents and falls, and getting lost.'*
>
> *'Being dumped with people you don't know.'*
>
> *'You get the mick taken out of you at school when they find out you are in foster care.'*
>
> *'It is important for people to ask how safe you are.'*

5.9. The extent to which children feel safe in settings away from home varies greatly, both within and between different establishments. Children in residential

[18] HMI Prisons full inspection of the Military Corrective Training Centre, Colchester, June 2004.

homes generally reported to inspectors that they feel safe with staff. However, from casework the Children's Rights Director has raised concerns about looked after children in some settings being afforded fewer safeguards than children living at home, because of untested assumptions about the level of protection that the care system must be affording them. He has also had significant concerns about unregulated children's homes and there are particularly disturbing, but exceptional, examples of children being cared for in caravans some distance from home by the unchecked staff of an unregistered provider. Because of action taken in these circumstances, including successful prosecutions and a Chief Inspector letter reminding all authorities not to place children in unregistered establishments, there is now a wider recognition of the potential risks involved in councils placing vulnerable children in the care of unregistered services.

5.10. In education settings, children generally feel safe and well supported by adults. In some residential special schools and colleges, however, staff are not always sufficiently attuned to the needs of lone pupils, who may not be part of a social group. The views of children and parents on boarding schools are particularly positive [*ref.27* http://www.csci.org.uk/publications/childrens_rights_director_reports/boardingschools_report.pdf], although in consultations they raised problems with children's separation from home and family, the need to counter bullying and homesickness and the need for privacy.

5.11 The Government asked the Children's Rights Director to consult privately fostered children on the draft regulations and National Minimum Standards it has prepared to improve safeguarding arrangements for children who are privately fostered, as described in paragraph 5.4. Privately fostered children strongly support the proposed improvements, but wish safeguarding measures to go even further [*ref. 63* http://www.csci.org.uk/publications/childrens_rights_director_reports/default.htm]. They want to be visited more frequently by social workers, at least in the first year of placement; to be able to speak to social workers away from the carer's home; to have a social worker's telephone number to call if they feel unsafe; to be able to request a visit from a social worker if they have concerns; to be supported in maintaining contact with their birth parents if they wish, and for both children and private foster carers to receive more information before placement. It is important that the experience of children informs the final version of the relevant regulations and National Minimum Standards.

5.12 A significant proportion of children are very distressed on arrival at young offender institutions, having already led unsafe lives in the community. Surveys[19] show that 25% of boys and almost 50% of girls feel depressed on arrival. They may then become exposed to significant risks of bullying and intimidation by

[19] HMI Prisons survey of a sample of young people's views in every young offender institution, 2003-04.

other children and of self-harming. The first *Safeguarding Children* report expressed considerable concern about conditions in young offender institutions, especially in relation to bullying. In 2003 and 2004 combined, there were more than 21,000 admissions to young offender institutions, but until January 2005, there had been no self-inflicted deaths among children for more than two years.

5.13 Around one third of boys and girls in young offender institutions say they have at some time felt unsafe, although this varies considerably between establishments. There is a small but significant minority – around 7% of children – who say they feel unsafe always or most of the time. HMI Prisons has also found a small minority who are clearly inappropriately placed in young offender institutions and who are therefore particularly vulnerable.

5.14 In secure children's homes and secure training centres, young people expressed similar feelings of uncertainty, particularly at the time of admission. However, these establishments have significantly better staffing ratios than young offender institutions. This is reflected in young people's view that bullying is identified at an early stage and there are robust policies and procedures in place providing protection to the victim and targeted work with the perpetrator. In the course of inspection work, inspectors always talk to young people. In most units, children say they feel safe and are well looked after and treated fairly. Self-harming is a regular occurrence in secure children's homes, reflecting the fact that many children placed in a secure setting are at risk of self-harming, or have already self-harmed.

5.15 Inspections of secure settings where children and young people are held have raised concerns in relation to children's rights and welfare. For young offender institutions, they include: the length of journeys to and arrival times, which can be late at night; strip-searching on arrival when young people are at their most vulnerable; and the use of segregation. For secure children's homes and training centres, there are concerns about the use of 'single separation', when children are confined to their rooms as part of the daily routine, and variations in practice on physical or intimate searches.

5.16 There is also concern about the use of force in young offender institutions to control behaviour, where procedures used on adults are also applied to children. Similar concerns have arisen about the suitability and safety of the various methods of physical control in use in secure children's homes and secure training centres. Physical control is also used in residential special schools, children's homes and some health settings, such as mental health units.

5.17 Following growing concerns, the Children's Rights Director canvassed the views of children and young people themselves in some of these settings. They had raised the use of physical control as an issue when asked about the main risks to them – *'Untrained staff trying to restrain you'* [*ref.28* http://www.csci.org.uk/publications/childrens_rights_director_reports/restraint_report.pdf]. They were concerned that adults working with children and young people

should know how to use physical control properly and without pain. They were also concerned by the use of physical control measures as punishments or to secure compliance with staff instructions. These are not acceptable uses for physical control or restraint, which is rather for preventing likely injury, serious damage to property or severe breakdown in order.

5.18 Concerns about physical control fall into four main categories:

- The under-use of other strategies for managing behaviour;
- The inappropriate nature of the methods used for physical control and its use at times for inappropriate purposes;
- Lack of staff training in how to: avoid pain and injury; apply de-escalation techniques; judge when restraint is appropriate or not; assess the outcomes of restraint for children; and use individual behaviour management plans to best respond to children's needs; and
- Lack of consistent monitoring of episodes of physical control, resulting in an incomplete national picture of the extent of its use.

5.19. A working party co-ordinated by the Youth Justice Board is currently considering the safety of practice in this area in settings where the Youth Justice Board makes placements. This is part of a wider review of the most effective methods of managing disruptive and challenging behaviour. This work is particularly timely since a young person sadly died in a secure training centre during a restraint in 2004. In parallel, an independent inquiry set up by the Howard League for Penal Reform is looking in detail at practice relating to strip-searching, segregation and physical control in secure settings.

5.20. The YJB is also seeking to establish a code of practice for behaviour management. It will include consideration of restrictive physical interventions with young people. The YJB is also seeking to engage with the DfES to see whether a common approach can be established so that a code of practice can be shared with open children's homes.

LISTENING TO CHILDREN AND YOUNG PEOPLE

5.21. One of the most common findings from the work of the Children's Rights Director is that children themselves want to be treated as individuals [*ref.6* http://www.csci.org.uk/publications/childrens_rights_director_reports/safe_from_harm_report.pdf], not just as one of many. Consulting children and taking their individual views and needs into account is important in providing tailored services and ensuring safeguarding. For children living away from home, means of achieving this include: providing access to reliable and trusted adults so that children's views and concerns are recognised; actively consulting and involving children,

parents and carers in decisions; and providing access to child-friendly and effective complaints procedures and advocacy arrangements.

5.22. Some children are happy with the level of contact and communication, while others feel isolated [*ref.14* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en].

> *'[It's helpful] having a social worker who does all she can and I have a lovely foster carer … knowing I will be listened to.'*
>
> *'I have been helped to live with my grandparents and can keep in touch with my friends.'*
>
> *'I wasn't questioned on how I felt whilst living at the foster home.'*
>
> *'[It's unhelpful] not knowing my social worker has left and then not having one…not having anyone from social services to talk to except a duty social worker who doesn't know me… having too many changes of social workers…when meetings are cancelled…not knowing who my social worker is.' [ref.15* http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf*]*
>
> *'Since I moved to my current placement, I found it difficult as I have been moved away from my friends and family to a place where I didn't know anyone.'*

5.23. Reliable adults can include foster carers, key workers, residential staff, social workers, relatives, independent visitors, or independent reviewing officers. They are important for all looked after children, but especially for children in out of area placements in foster care, children's homes or residential special schools. Those children often have infrequent contact with their social worker from their placing council, their views are not always sought or listened to and advocacy is under-developed.

5.24. In practice, staff shortages within social services can undermine the ability to provide such contacts. A review of 30 councils in 2003 showed that only half the councils had allocated all looked after children to a social worker[20]. This places additional responsibility on the child's immediate carer to consider their best interests, and safeguarding concerns arise if the child wishes to raise issues about their carer. Social services often fail to arrange for a looked after child who is not in touch with their family to have an independent visitor which, subject to the individual child's wishes and welfare, they should consider providing.

[20] Social Services Inspectorate, *Review of Delivery and Improvement Statements for Children's Services in 30 Councils*, 2003.

5.25. In specialist centres in the NHS, staff recognise the difficulties experienced by children with complex needs who have access to many different medical consultants. Some trusts, such as Great Ormond Street Hospital, have appointed a consultant paediatrician with a general responsibility for co-ordinating the care of individual children. Other trusts visited were seeking to employ either a nurse or other health care specialist to provide a coordinating role.

> *'Usually I have like a senior house officer, they kind of go to different hospitals to build their experience. So I usually see one of them which is annoying because it changes every time I come, by the time they've got to acquaint themselves with my notes.' [ref.29* http://www.city.ac.uk/chrpu/projects/healthyfutures/report/pdf/hf_cover.pdf*]*

Good practice

Great Ormond Street Hospital has a children's website which provides age-appropriate information for children and young people, who were involved in its development. They can ask questions about their condition and make contact with others with similar complex conditions.

[Healthcare Commission/CSCI]

5.26. In young offender institutions (YOIs), prison officers in their capacity as personal officers, or key workers to individual children, are very important as adult role models. But some establishments regard personal officers as a greater priority than others and the function remains seriously under-developed. There should be a strong emphasis on teamwork across the establishment and the growing numbers of social workers, advocates and other specialist staff should support and enable personal officers rather than displace and marginalise them.

5.27. The extent to which services consult children and involve families and carers varies considerably. Most councils consult with looked after children as part of their corporate parenting responsibilities, sometimes with a range of creative approaches. Groups of looked after children have been involved in designing consultation leaflets and there is increasing use of specialist software to consult children. However, it is not always evident to young people, or inspectors, that their views are acted upon or lead to better outcomes.

Good practice

Bethlem adolescent unit, part of South London and Maudsley NHS Trust which provides mental health services, has redesigned the unit as part of a series of initiatives to address children's safeguarding needs. Young people using the unit were consulted about its redesign and the design of the planned secure unit.

Birmingham Children's Hospital NHS Trust, has also developed a purpose-built, modern in-patient, adolescent CAMHS unit, which is located separately from the

main Trust site and viewed positively by young people and their carers.

[Healthcare Commission/CSCI]

5.28. The involvement of children in drawing up or reviewing their care plan also varies. Social workers do not consistently spend time with children to find out their wishes and feelings for their future, although this is a fundamental part of a social worker's role, and depend too much on feedback from other agencies involved with the child or commissioned to establish their views. In children's homes, the opinions of children and their families are generally sought about key decisions and 78% (1,204) of homes inspected fully met or exceeded the National Minimum Standard in this respect[21]. New statutory requirements for independent reviewing officers (IROs) were introduced in September 2004. The role is intended to improve the quality of care planning and decision making for looked after children, and IROs have a particular responsibility to make sure that the care planning process takes account of the child's views.

Good practice

To promote best practice in service provision for black and minority ethnic children, Leicester City Council set up Black Cases Panels to review the cases of individual children in need, looked after children and care leavers. The panels produce an annual action plan based on lessons learned and gaps in services identified. This approach is based on Leicester's nationally recognised Heritage Model, through which staff explore with service users how aspects of their individual heritage and cultural needs should influence the services they require.

[CSCI]

5.29. Schools generally seek and take into account the views of children. 87% (151) of residential special schools and 82% of boarding schools fully met or exceeded the National Minimum Standard for consulting children[22]. However, some of the residential special schools visited for this review did not always give pupils sufficient opportunities to develop skills of self-advocacy and assertiveness, for example through the personal, social and health education curriculum. In the residential specialist colleges visited, students felt they have good access to learning opportunities for self-advocacy and self-protection.

5.30. Young offender institutions vary in the encouragement and support they provide to maintaining family links, although some successful schemes have been developed. Some secure children's homes have consultative groups while some ask children, parents, carers and placing agencies to give feedback on

[21] National Care Standards Commission, Inspections of National Minimum Standards, 2003-04, inspections of 1,564 children's homes.
[22] National Care Standards Commission, Inspections of National Minimum Standards, 2003-04, inspections of 174 residential special schools; and 2002-04, inspections of 208 boarding schools.

services. Secure children's homes encourage contact between children and parents or carers, who are kept well informed.

5.31. The existence, effectiveness and child-friendliness of complaints procedures also vary. Surveys of looked after children during inspections of social services show that the majority know how to make a complaint and independent reviewing officers remind children of the complaints service during their reviews. There are good advocacy systems in an increasing number of councils, as required by legislation[23], many of which are commissioned from the independent sector. Initiatives by children's rights officers include involving children and young people in writing complaints leaflets, running children's rights groups for children with disabilities and supporting children in making complaints. However, there is insufficient support for social workers to help with consultation and advocacy for children with complex needs, including communication disorders. Systems for checking whether looked after children believe they have been listened to and taken seriously are not always effective.

Good practice

In West Berkshire children feel safe and have their views taken into account. The Independent Visitor Mentoring and Advocacy Scheme visits all looked after children in out of area placements and attends the children's reviews.

[CSCI]

5.32. Although less than 50% (79) of residential special schools met the National Minimum Standard for responding to complaints, most of the others nearly met the standard. However, in the schools visited, few parents and carers were aware of formal complaints procedures, although they generally felt able to contact the school informally about concerns. In boarding schools, there have been significant improvements in meeting national minimum standards relating to listening to children. Complaints procedures are fully in place in only 41% (85) of schools inspected, with a further 54% nearly meeting the National Minimum Standard for responding to complaints[24].

5.33. In young offender institutions, children frequently do not complain since their expectations are low or they may not wish to upset the system, and they often have little experience of formal procedures. This underlines the importance of the personal officer and other staff in recognising and passing on matters that are of concern to the child. All young offender institutions have provided advocacy services since March 2005.

5.34. All secure children's homes and secure training centres have complaints procedures and there is growing evidence that complaints are taken seriously

[23] S119 of the Adoption and Children Act 2002 requires councils to have advocacy services in place.
[24] National Care Standards Commission Inspections. See note 17.

and responded to in effective ways. Some establishments have developed imaginative ways of encouraging and enabling children to express their views, and the units where complaints are given priority are generally those where children express most confidence in the system. Independent advocacy services are regular visitors to secure training centres and secure children's homes, providing an important external link for young people.

MAKING SAFEGUARDING A PRIORITY

5.35. The priority that agencies give to safeguarding in policies and planning for children living away from home has progressed since the last safeguards review. However, this is not the case in all settings, and there are concerns about how far the safeguarding needs of particular groups of children are prioritised or met.

5.36. National developments have led to improvements in safeguards for certain groups of children, such as those in prison custody. Following the Howard League judgment, a major review to examine safeguarding arrangements in all YOIs that held children [*ref.30*] concluded that there were weaknesses in safeguarding practice. A safeguarding action plan was generated for every YOI, and a report with recommendations was issued and is being implemented.'[*ref.31* http://www.hmprisonservice.gov.uk/resourcecentre/psispsos/listpsos/index.asp?startrow=51]. However, much has still to be done to produce detailed guidance in specific areas of safeguarding such as bullying, behaviour management and the care of the very vulnerable. The Youth Justice Board is also consulting widely on a new strategy for the secure estate, stressing the importance of promoting safe custody throughout.

5.37. There is often a strong commitment at senior levels in individual agencies to prioritising the needs of children and recognising their vulnerability. Elected member concern for safeguarding looked after children has increased significantly and councillors pay considerable attention to their statutory duty to provide a corporate parenting role. In some councils, this includes making contact with children and young people placed away from their home area and monitoring their well-being. The commissioning, purchase and monitoring of external placements of looked after children are a high priority for elected members and senior managers. This is driven by the high costs involved and poor outcomes for the children concerned.

5.38. Most councils recognise the need to minimise the factors that lead to children being looked after and to provide better access to placements nearer home. The best councils are developing a combination of preventive services, including family support and work with adolescents at risk of entering the care system, and better placement choice. This is achieved through a supply of local children's homes, well-supported foster carers and partnerships with independent fostering agencies. Inter-agency panels and regional commissioning are also starting to counter what was previously a 'seller's market' for placements. However, there is still a long way to go, especially for children with complex

needs. The pace of change has been slow and has been held back by difficulties in switching resources and by staff turnover.

5.39. Overall, greater priority is now given to safeguarding in individual agencies' policies and procedures, but they vary considerably in their coverage and quality. For example:

- the child protection systems in 6.5% of children's homes inspected did not meet the National Minimum Standard, with another third of the homes inspected falling slightly below the standard. Similarly, 10% of fostering services inspected did not meet, and an additional third of those inspected did not fully meet, the equivalent standard[25];

- the existence of child protection procedures in schools is also variable. 40% (70) of residential special schools did not meet or only partially met the National Minimum Standard for child protection systems and procedures, while nearly 60% (124) of boarding schools inspected did not pass on that standard[26];

- most residential special schools and boarding schools have anti-bullying policies, and some are excellent at dealing with bullying, although some of the residential special schools visited do not sufficiently recognise the additional needs of children with disabilities in relation to safeguarding; and

- secure children's homes, secure training centres and young offender institutions generally have good policies and procedures for child protection, although not all are agreed with the ACPC. This is not necessarily the responsibility of the establishment, since some ACPCs have been slow in welcoming their involvement. Establishments have policies and increasingly effective practices for monitoring children at risk of self-harm and all have anti-bullying policies.

5.40. There are some groups of children whose safeguarding needs are recognised but for whom support services are inadequate or unsuitable. Some children of 15+ have been inappropriately placed in young offender institutions, despite attempts by the Youth Justice Board and youth offending teams to place them appropriately. Similarly, there is a national shortage of secure CAMHS beds and a lack of suitable settings to meet the mental health needs of young people with special needs. Some children with a severe or chronic mental disorder are therefore placed in secure settings. These children are often the most disordered, vulnerable and challenging and their needs cannot be

[25] National Care Standards Commission, Inspections of National Minimum Standards, 2003-04, inspections of 1,564 children's homes and 206 fostering services.
[26] National Care Standards Commission Inspections. See note 17.

appropriately met in these settings. In addition, their presence can significantly affect the stability of an entire unit.

5.41. Children also need to be adequately safeguarded at transition points in their lives, especially where they move in and out of services or from one geographical area to another. Attention given to this is variable. Critical points include transitions:

- to a new school in a new LEA, especially if this coincides with a move from primary to secondary schooling;
- to adult health care services for children with a chronic illness, complex health needs or mental health condition;
- to adult social care services for looked after young people with disabilities;
- from care to independent living. Some councils manage this well, with a comprehensive multi-service approach. In other places, outcomes for care-leavers are less of a priority; and
- from secure settings back into the community.

ASSURING SAFEGUARDING IN PRACTICE

5.42. Services for children in public care are highly regulated. CSCI inspects councils' children's social services and regulates children's homes and foster care, and inspects the welfare of children in boarding and residential special schools, to National Minimum Standards. Regulatory inspections are being reviewed to provide a clearer focus on outcomes for children. In addition, the Children's Rights Director within CSCI has an independent statutory role in safeguarding and promoting the rights and welfare of children. He recently consulted children living away from home about their experiences of inspection and their views will inform future inspection processes [*ref.51* http://www.csci.org.uk/media/press_releases/childrens_views_of_inspection.pdf]. Opportunities to share learning through inspection are not fully exploited: not all inspectorates consistently provide an overview of information and disseminate good practice in children's safeguards identified through inspection work.

5.43. The previous chapter raised concerns about how far safeguarding policies and procedures for children who live at home are embedded in practice and monitored. This is also a concern for looked after children. Councils have procedures for monitoring placements of looked after children, including those placed away from their home area, but there is an assumption that once practitioners have understood procedures they will be implemented and little further monitoring takes place. This puts safeguarding at risk. Key findings include:

- few councils identify specific safeguarding requirements in placement contracts for looked after children or have a system to monitor their application. There is little feedback about incidents from social workers to placement commissioners to inform decision-making about future placements;

- the system for notification of children placed in another local council area is haphazard and officers in receiving councils say that some placements are made without notifying them or sufficiently checking standards;

- placements with family or friends are often not sufficiently monitored; and

- social workers do not consistently visit looked after children.

The strengthened role of the Independent Reviewing Officers (see paragraph 5.28) does have the potential to improve safeguarding for looked after children. The role includes the responsibility to ensure effective care planning, the child and family's access to advocacy and the complaints procedure as appropriate. Ultimately, if the council did not carry out its duties responsibly, with the possibility that the child's human rights might be breached, IROs have the power to refer the case to the Children and Family Court Advisory and Support Service (CAFCASS) who could take the case to court on behalf of the child.

WORKING TOGETHER TO SAFEGUARD CHILDREN AND YOUNG PEOPLE

5.44. Children living away from home often have contact with many agencies and experience a range of different settings. For example, 40% of children in young offender institutions say they have been in care or have a care history, while 83% have at some time been excluded from school. Frequently, very little information about this background is available to the staff caring for them. In these cases, identifying and sharing information about children is vitally important in planning a suitable response to their individual needs. It is also essential that staff know how to recognise welfare needs and report them to social services where necessary.

Sharing information and assessing needs

5.45. Arrangements between agencies for providing and sharing information about children to assist needs assessment and identify safeguarding issues vary considerably.

5.46. Where looked after children are placed out of area, there is evidence that the system for notifying receiving councils is not working well. One council estimated there might be substantial numbers of children in their area of whom they are unaware. Councils are even less likely to be informed when children move out of placements in their area, so their lists are out of date. Although the statutory Code of Practice on school admissions, which was revised in 2003,

recommends that admission authorities should give looked after children top priority in their over-subscription criteria, LEAs and schools do not always give sufficient priority to the early provision of school places to looked after children who are placed by a different council. The lack of clarity about who is responsible for providing background information to the school often hinders speed of provision. A Department for Education and Skills working group on looked after children in out of authority placements is reviewing a range of issues, including the need to strengthen the notifications process. Inspection evidence demonstrates the need for the system to be made more robust. In future, information sharing index systems which may be established under S12 of the Children Act 2004 will help, as a key function of any system to be developed would be the ability to operate between different local areas. This would assist in the onward provision of support.

5.47. Similarly, arrangements for notifications of looked after children from the placing council and NHS trust to the receiving NHS trust are often unclear, and health information can be delayed or not provided at all. Healthcare provision may therefore be disrupted following a child's move. This has a particularly adverse impact on looked after children in need of CAMHS services, where fast-track arrangements in the home authority are not in place outside it. The government is currently consulting on revised arrangements for determining responsibility for commissioning health services for children living away from home.

Good practice

East Midlands regional protocol covers nine councils and supports arrangements for looked after children and their education when children move across council boundaries. The protocol is supported by all directors of education and representatives of the Association of Directors of Social Services.

[Ofsted/CSCI]

5.48. Children are often placed in residential settings or foster care without full background details or risk issues being shared with the provider to enable them to care for children safely. Where full risk assessments are carried out in residential settings, the identified risks are not always addressed. For example, there are cases of young people with a history of abusing children being placed in a dormitory with younger children. Agency contributions to assessments are not always well co-ordinated, particularly for annual reviews of looked after children with statements of special educational needs when they are placed away from home in residential special schools. Where the *Assessment Framework for Children in Need and Their Families* has been used effectively for new placements to inform the care plan, the higher quality of information has led to better outcomes for these children [*ref.17* http://www.archive.official-documents.co.uk/document/doh/facn/fw-00.htm].

5.49. Many children arriving in young offender institutions are already vulnerable because of their earlier experiences, and are at risk of suicide and self-harm, bullying and intimidation. Some children adapt particularly badly to life in custody. Establishments should give high priority to the vulnerability assessment prescribed by the Youth Justice Board for children on arrival. The young person should also be accompanied by the assessment carried out at court by a youth offending team worker. The availability and quality of the vulnerability assessments has improved since the last review but there is still scope for improving the recording of their findings and conclusions.

5.50. Secure training centres have clear procedures for ensuring effective risk assessments are carried out at admission and updated as the placement progresses. Like young offender institutions, secure training centres have benefited from improved provision of information, but it is often lacking in accuracy and detail. Secure children's homes have procedures for risk assessment on admission, but the results are not always well recorded and the quality of records in general is variable. Information from placing authorities is sometimes missing or incomplete.

Raising welfare concerns

5.51. There is much variation in arrangements for identifying and notifying social services and other agencies of welfare concerns or issues. There are also some reports of social services failing to treat welfare concerns with sufficient priority, as highlighted in the previous chapter.

5.52. Many children's homes report difficulties in persuading social services that child protection referrals meet thresholds. However, children's homes themselves do not consistently report serious incidents to inspectors, such as children who go missing or run away. Joint protocols with the police for missing children are increasingly common but staff are sometimes unaware of them and the police response varies. In 2005, the Association of Chief Police Officers (ACPO) issued guidance to all police forces on the *Management, Recording and Investigation of Missing Persons [Ref 62* http://www.acpo.police.uk/asp/policies/Data/missing_persons_2005_24x02x05.pdf*]*. Putting this guidance into practice will result in greater consistency in how the police respond to reports that looked after children have gone missing from their care placement.

5.53. Boarding schools and residential special schools are often unclear about which council they should notify about child protection concerns and sometimes receive confusing responses from social services, in spite of the existence of clear guidelines.

5.54. In the specialist hospitals reviewed, large and numerous files that are hard to navigate make it difficult to identify welfare concerns. Most of the trusts had undertaken audits of records and were looking at methods to improve

accessibility of the files. These include introducing front sheets containing clear biographical information and amalgamating duplicate sets of notes. Trusts' incident reporting systems are not always robust and some staff are unclear about child protection procedures or how to get advice after hours. There is also an absence of post-mortem protocols in some hospitals, so it is not always clear at what point it might be necessary to refer a case to a coroner or to consider a Serious Case Review.

5.55. NHS organisations are required to notify social services of all children who spend more than three months in hospital so that their welfare needs can be assessed[27]. In practice, some NHS staff are not aware of this requirement. In addition, almost two thirds of social services departments do not have an agreed protocol with local trusts about this requirement and a quarter do not have a recording system specifically for children in this category.

5.56. In young offender institutions, the reporting of and response to child protection concerns has been inconsistent, despite the Howard League judgment [*ref.26* . http://www.lawreports.co.uk/qbnovc0.3.htm]. There have been wide variations in the numbers of referrals, reports of unsatisfactory responses from social services and incomplete or poorly recorded investigations. There is still considerable scope for improvement, but there are now signs of progress. This is assisted by the issuing of a Department for Education and Skills circular in July 2004, underlining the obligations of councils to children in custody [*ref.32* http://www.dfes.gov.uk/childrenandfamilies/cfcirculars.shtml#LAC]. Also, the Youth Justice Board has provided funding of specialist social workers to work with young offender institutions.

ENSURING SAFE ADULTS WORK WITH CHILDREN AND YOUNG PEOPLE

5.57. There are many committed and highly skilled staff working with children living away from home, but they are often under considerable pressure because of staff turnover or difficulties with recruitment. Such difficulties in respect of social services staff are noted in Chapter 4. They also apply to prison staff, especially in London and the south east, and in secure children's homes and secure training centres, many of which are unable to meet consistently the staffing levels set out within their statement of purpose. This has significant implications for safeguarding. Staffing ratios in young offender institutions are already low in relation to other secure settings, which reduces opportunities to develop the role of personal officers discussed earlier (paragraph 5.20).

5.58. The Warner report made recommendations for ensuring staff working in children's homes and residential schools are suitable for such employment[28]. In

[27] Under sections 85/86 of the Children Act 1989.
[28] Warner, N. *Choosing with Care: the Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes.* London: HMSO, 1992.

some areas, there have been significant improvements to selection and recruitment processes, for example for foster carers. However, there are continuing concerns across services about staff recruitment and vetting practices. These include:

- allowing staff to start work before the results of a new Criminal Records Bureau (CRB) check have been received, for example in some secure children's homes inspected and some local authority residential special schools. Secure children's homes indicate that staff would not be allowed unsupervised contact with children until the CRB check results were received. However, this means than an essential safeguard is being applied inconsistently and this is contrary to current regulations[29]. Councils also cite delays in CRB clearance increasing the risk of losing staff and exacerbating staff shortages. This was the case when the CRB was first set up, but since CRB performance has improved it also reflects some providers' failure to progress applications for checks promptly;

- checking of staff from outside the UK. Many foreign doctors come on postgraduate placements to gain experience with children who have complex needs, but the CRB is unable to carry out checks outside the UK. Inspections of independent and voluntary sector health providers reveal a similar situation and there are similar concerns about staff from abroad in some children's homes;

- lack of checks where the employment history is incomplete and little verification of references, for example in some residential special schools, boarding schools and secure children's homes. In some children's homes, references were not on file and there were concerns where positive written references had been followed up by off-the-record negative comments from previous employers;

- little rechecking of staff already in post, for example in boarding schools. There is no requirement for boarding schools, as there is for children's homes, that all staff, including those already in post, should have been subject to a new CRB check. Similarly, prison officers appointed, promoted or transferred after April 2002 are checked up to enhanced CRB level. Staff remaining on the same grade who would have been subject to the standard criminal records checks do not undergo any further re-checking; and

- the supplying of staff to regulated children's settings by unregulated recruitment agencies, which are sometimes reluctant to divulge 'confidential' information about staff. There are also reports of some foster carers moving between agencies, despite previous concerns about them.

[29] Regulation 26 of the Children's Homes Regulations 2001.

Good practice

In addition to carrying out enhanced CRB checks for all new staff and contracted staff who have contact with children and young people, Great Ormond Street Hospital also rechecks all staff who move to different directorates within the Trust.

[Healthcare Commission/CSCI]

5.59. Training for staff who work with children living away from home is improving but still variable. Foster carers are generally trained in child protection, but access to training on other safeguarding issues varies and supervision of carers is inconsistent. Although 62% (970) of children's homes inspected met or exceeded the National Minimum Standard for child protection systems and training[30], inspections have raised concerns about the numbers of staff in independent children's homes who lack skills, experience and training.

5.60. In education settings, the standard of staff training also varies. The boarding schools sector has introduced its own externally validated national welfare and safeguarding training programme for all boarding staff and boarding schools normally have at least one member of staff trained in child protection. Nonetheless, a high proportion of both boarding schools and residential special schools (60% and 40% respectively) did not meet or only partially met the National Minimum Standard for child protection systems and training[31].

5.61. For prison staff, there was no national training for working with young people before mid 2004. The Prison Service[32] and Youth Justice Board then introduced a new seven-day training course for prison officers with a target of training all staff working with children by 2007. However, arrangements are not always in place to enable staff to be released for training.

5.62. In some young offender institutions, secure children's homes and secure training centres, the quality and extent of child protection training is variable while in others it is of an excellent standard. The secure children's homes and training centres that offer effective training are generally those that have forged good relationships with their ACPC. However, in some units, night staff are not trained and there is a lack of refresher training.

CONCLUSIONS

5.63. Recognition of the safeguarding needs of children who live away from home has increased since 2002. Agencies are now giving more priority to developing services for, consulting and communicating with, and ensuring

[30] National Care Standards Commission Inspections. See note 16.
[31] National Care Standards Commission Inspections. See note 17.
[32] The Prison Service and the Probation Service merged in June 2004 to form the National Offender Management Service.

safeguards for these children. There is evidence of improvement at a national level, for example in the attention given to safeguarding children in prison custody. There are also examples of strong commitment at senior levels to safeguarding children looked after, for example by elected members.

5.64. However, there are some areas of policy and practice in relation to children who live away from home that are in need of significant improvement. There is still an assumption that because these children are already in care or under supervision, they must be safe, despite the fact that the extent to which children themselves feel safe varies considerably. This level of complacency militates against effective safeguarding. Key areas for improvement include:

- contact for all children with people to whom they can express their views or concerns. Social services do not consistently ensure that independent visitors are in place (subject to the child's wishes) when a child is not in contact with their family;

- practices in relation to the physical control in many settings where children are cared for. The use of strip-searching and single separation in young offender institutions, local authority secure children's homes and secure training centres also needs to be reviewed;

- ensuring that there are policies and procedures for child protection in all settings, especially in some education settings;

- priority to the safeguarding needs of all children, including vulnerable boys and girls inappropriately placed in young offender institutions and children with a mental health condition admitted to secure settings. There is a need for continuity of care and provision for children in transition between areas or institutions;

- consistent arrangements by councils to monitor placements adequately, especially those outside the home area;

- robust arrangements for sharing information to identify welfare issues and needs. This is particularly important where children are placed in a council area by another placing council;

- ensuring all agencies consistently and appropriately raise welfare or child protection concerns;

- effective notification from NHS organisations to local councils about children who spend more than three months in hospital so that their welfare needs can be assessed; and

- effective recruitment processes and staff checking procedures across all settings.

6. CHILDREN AND THE JUSTICE SYSTEM

INTRODUCTION

6.1. The first *Safeguarding Children* report included a chapter on young people who commit offences. Children also experience the justice system in various other ways: in family proceedings and as victims of and witnesses to crimes. This chapter explores children's experiences and the safeguarding arrangements in place in those settings as well as assessing progress with the safeguarding of children and young people who commit offences. The scope of this chapter does not include the safeguarding work with children and young people carried out by the police.

6.2. There are many different agencies and organisations involved in the justice system. The first *Safeguarding Children* report highlighted that further work on aspects of the justice system was necessary, and this chapter draws on inspection work in some of the agencies concerned. However, the picture this chapter provides of how well children are safeguarded is only partial. Inspection arrangements have not covered every aspect of the justice system since there are parts of it that have been outside the remit of inspectorates and will remain so. There is a particular gap in respect of the higher courts, since it is only very recently that a unified courts service has been set up[33], with associated unified inspection arrangements for the administration of HM Courts Service.

6.3. Also, while systems exist or are being developed for inter-agency collaboration within different parts of the justice system[34], there have been limited mechanisms for sharing information and good practice on safeguarding between the criminal and the family justice systems. New arrangements in the courts service therefore provide an opportunity to develop a more consistent approach to the safeguarding of children and young people.

CHILDREN IN FAMILY PROCEEDINGS

6.4. This section looks at the steps taken by the relevant agencies to safeguard children during family proceedings. Family proceedings involve, for example, care proceedings, adoption arrangements or contact and maintenance agreements for children whose parents are separated or divorced. The outcome

[33] The Courts Act 2003 established Her Majesty's Courts Service as a unified court administration across England and Wales from 2005. HM Magistrates' Courts Service Inspectorate also became HM Inspectorate of Court Administration with inspection responsibilities across the courts service. Inspectors do not inspect persons making judicial decisions or exercising any judicial discretion.
[34] Local Criminal Justice Boards established in April 2003 bring together local agencies at a strategic level in 42 Criminal Justice System areas. They include the police, Crown Prosecution Service, magistrates' and Crown Courts, National Offender Management Service and youth offending teams. A similar system for family justice is likely to establish 42 Local Family Justice Councils during 2005.

of these proceedings usually has a significant impact on the future lives of children. It is beyond the scope of this report to comment on policy or practice in relation to judicial decisions.

6.5. The Children and Family Court Advisory and Support Service (CAFCASS) is responsible for promoting the welfare of children in family proceedings. In 2003-04, it dealt with nearly 34,000 private law cases and more than 13,000 public law cases. Overall, nearly 74,000 children and young people were involved. This section draws on evidence from inspections of CAFCASS in England and Wales from March to December 2004 and visits to six care centres[35] and linked magistrates courts in England [*ref.34*. http://www.hmica.gov.uk/files/53472_cd.pdf].

Making safeguarding a priority

6.6. Both CAFCASS and the courts emphasise and promote children's statutory rights. However, the term 'safeguarding children' is not consistently understood and used by either CAFCASS or the courts. This is partly because the courts have not been extensively involved in previous reviews of safeguards. It also reflects confusion in the context of family proceedings about the term 'safeguarding', which is generally associated with the narrower focus of child protection. Such confusion is a barrier to effective inter-agency working and understanding.

6.7. As a result, while there are elements of good safeguarding policy and practice, they are not brought within an explicit safeguarding agenda to build on the commitment to promote children's rights. During inspections, staff expressed considerable interest in the concept of safeguarding, but this has not so far been reinforced by a wider, multi-agency debate about what safeguarding means for family proceedings. Furthermore, CAFCASS does not yet fully address diversity issues either in recruitment or in front-line practice, and this is reflected in its reports to court.

6.8. Whether children should participate and be involved in family proceedings is the subject of widely diverging views. Currently, most children have little or no say in formal arrangements about their future, such as where they will live or with whom they will have contact. CAFCASS has developed a draft child participation policy and has a programme of work to enhance the involvement of children but practitioners vary considerably in the extent to which they believe children should be actively involved in private law cases. Also, although staff are required to report to the court on the child's wishes and feelings, report reading by researchers and inspectors shows that a summary or an interpretation is sometimes substituted for the child's own words. Since children rarely attend

[35] Within the current structure of courts that deal with family proceedings, care centres are county courts whose jurisdiction covers the full range of public and private law.

court, the opportunity accurately to represent and take into account their views is therefore weakened.

6.9. The courts rarely encourage children to attend, except in adoption cases where there is often a child-centred and celebratory approach. There is little conclusive research evidence to support or negate greater child involvement in family proceedings, including attendance at court. However, some research shows that children themselves often wish to be more involved in family proceedings [*ref.35* http://www.nspcc.org.uk/inform/downloads/YourShout.pdf]. Involving children could contribute to achieving improved outcomes by giving them a better understanding of their situation and greater engagement with the court's decision and its impact on their lives.

6.10. In practice, child attendance at court is only one of a range of options for giving children greater involvement in decisions about their future. There is also scope for agencies involved in family proceedings to work together to consider other options, which include:

- giving children party status within statutory provisions and other linked procedures;
- giving children age-appropriate information about the proceedings from commencement to conclusion, including any necessary follow-up;
- where requested by courts, seeking children's wishes and feelings about the reasons underlying the court proceedings and reporting such matters to courts, orally or in writing;
- facilitating children's attendance at court for appropriate parts of the proceedings or for pre-hearing court visits; and
- seeking children's views as service users about the quality of services received, primarily through agency customer surveys but also on occasions through inspection, research or other methods.

6.11. Effective safeguarding in practice has been significantly hindered by widespread and chronic delays in allocating CAFCASS staff to both public and private law proceedings. Steps have been taken to address delays but they remain a problem in some areas. In court proceedings, the *Protocol for Public Law* aims to enable courts to deal fairly, sensitively and efficiently with cases involving children and families in public law proceedings [*ref.36* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/LocalAuthorityCirculars/AllLocalAuthorityCirculars/LocalAuthorityCircularsArticle/fs/en?CONTENT_ID=4068210&chk=EIYVVR and http://lawzone.thelawyer.com/cgi-bin/item.cgi?id=111452&d=204&h=240&f=209]. It is too early to determine if the protocol has had a significant impact on reducing delays. However, a few courts have established case progression officers to help ensure compliance with the

Protocol. Court staff indicate that these posts have made a positive contribution, both to inter-agency working and to reducing delay.

6.12. CAFCASS invests considerable management time in inter-agency collaboration, attending around 150 ACPC meetings and sub-committees and around 40 Family Court Business Committees. Despite this level of involvement, there is no agency-wide mechanism for sharing general information relevant to safeguarding. There is little involvement in ACPCs of court staff or magistrates. How to achieve greater involvement from the wide range of agencies who work with children is a recurring theme for consideration in setting up Local Safeguarding Children Boards.

6.13. In common with some other services, there has been some concern about lax recruitment procedures in CAFCASS, particularly in relation to staff who have direct contact with children. Plans have been introduced to strengthen procedures, including ensuring that staff are appropriately checked with the Criminal Records Bureau (CRB).

CHILDREN WHO ARE VICTIMS OF, OR WITNESSES TO, CRIME

6.14. Children who are victims and/or witnesses in criminal proceedings need special care. This section examines arrangements for safeguarding these children. It draws on area inspections and thematic reviews of safeguarding arrangements in the Crown Prosecution Service. The Crown Prosecution Service prosecutes people who have been charged with a criminal offence. It advises the police on cases for possible prosecution, reviews cases submitted by the police and prepares and presents cases at court. Under new statutory and shadow charging schemes, prosecutors are providing early advice to the police before charges are brought and making the charging decision in more serious and contested cases. The aim is to lead to improved case building and, while the time between arrest and charging may increase in some cases, delays in progressing cases in courts should reduce.

Making safeguarding a priority

6.15. The Crown Prosecution Service pays attention to safeguarding children in some aspects of its work and arrangements. For example, it attaches particular importance to cases involving child abuse and domestic violence and this is reinforced by domestic violence co-ordinators and child abuse specialists in Crown Prosecution Service Areas (although the latter are not a formal requirement). There is no explicit strategy for considering the wider safeguarding issues of children in criminal proceedings and an overall approach to considering children as victims needs to be developed.

6.16. The lack of an overall approach to safeguarding is reflected in the varying links that Crown Prosecution Service Areas have with ACPCs, despite a recommendation in the first *Safeguarding Children* report that they should be

developed. The Crown Prosecution Service is not among the statutory partners in the new Local Safeguarding Children Boards and the role and involvement of Areas will need to be considered in consultation and guidance. Similarly, although some Areas are involved with Multi Agency Public Protection Panels, whose primary focus is public protection including child protection, there is no national policy on this issue.

Children as victims

6.17. The Crown Prosecution Service has a child abuse policy and accompanying guidance. These have not been updated for some time, although guidance has been issued on relevant statutory changes including particular implications for children. Most Areas have child abuse specialists, but there is no formal requirement for them to do so and they do not exclusively handle all child abuse cases in all Areas. There are limited opportunities to share information on and learning from child abuse cases and little data is collected or analysed nationally on child abuse cases and trends.

6.18. The Crown Prosecution Service has issued a model joint protocol between the police, prosecutors and social services for the exchange of information during the investigation and prosecution of child abuse cases. This covers the circumstances, process and procedures for sharing information between the agencies, and in particular sensitive and third party material for disclosure. However, not all 42 criminal justice system areas have implemented it, and there are some local difficulties in getting all parties to sign up to it. The existence of protocols governing the timeliness and quality of and access to medical evidence in child abuse cases varies between Areas. Where written protocols do not exist, liaison arrangements depend on staff continuity and co-operation.

6.19. The handling of child abuse cases and the quality of child abuse casework and preparation are generally satisfactory. Where performance is good, it includes the use of child abuse specialists, the correct application of policy and the achievement of expeditious and appropriate guilty pleas. Most files are always properly identified as child abuse cases, but a few are not and this can cause delays or mean that an appropriate specialist is not assigned to the case. Also, in many cases, files do not show that a lawyer has seen and assessed the quality of video evidence given by a child. The absence of adequate records in this respect is of concern. One Area has addressed this by introducing a form for the reviewing lawyer to record that they have watched and assessed the videotape of the child's interview.

6.20. In cases of domestic violence, the direct and indirect effects and long-term psychological impact on children are widely acknowledged. A thematic inspection of the handling of domestic violence cases by the police and the Crown Prosecution Service found that the presence of children was not automatically recorded or notified by police, although recent inspection work found that this issue is actively being addressed [*ref.37*

http://www.homeoffice.gov.uk/hmic/dvrep.pdf]. Also, the police and prosecutors were reluctant to involve children in cases. In many cases, files sampled did not show clearly if children were involved, and where they were, that the children's safety and interests had been considered. There were examples where a significant risk to a child was apparently ignored. Neither did the files always indicate if the child is to be used as a witness and the reason for the decision. To address these issues the Crown Prosecution Service has produced revised policy and guidance, with a supporting national training pack, which explicitly requires prosecutors to consider the views of a child [*ref.38* http://www.cps.gov.uk/publications/docs/DomesticViolencePolicy.pdf]. Diversity issues are also specifically addressed.

Children as witnesses

6.21. NSPCC research into child witnesses' experiences, mostly in sexual offence cases, found that waiting for a trial to start is stressful and giving evidence is itself traumatic [*ref.39* http://www.nspcc.org.uk/inform/Research/Summaries/InTheirOwnWords.asp]. The testing of evidence by defence counsel is often intimidating and not always couched in language that children understand. The NSPCC research identified a number of shortcomings in witness support for children, including vulnerabilities not picked up and brought to the court's attention, lack of pre-trial contact with a supporter, delays on the day of the trial and little choice about how children could give evidence.

> *'The defence wasn't nice. He was horrible. He said I was a liar. No one warned me beforehand that he'd say that… There were things I wanted to say but didn't get a chance to say.' (Jason, 10)* [*ref.39* http://www.nspcc.org.uk/inform/Research/Summaries/InTheirOwnWords.asp]

6.22. There is now great emphasis nationally on the care and support of witnesses and various measures are in place for supporting children and their parents or carers through the court process, provided by both public and voluntary sector organisations. Under the "No Witness, No Justice" scheme[36] specialist witness care units provide a single contact point for victims and witnesses. All witnesses who are being called to court have their needs assessed to identify any problems which could prevent them giving evidence or attending. Such problems include transport problems, language difficulties, disabilities or fears of intimidation. Training for witness care officers will address the specific needs of children. In some police forces, Child Abuse Investigation Unit staff who are involved in a particular case also provide support. Liaison is

[36] A joint Crown Prosecution Service and police project established on a pilot basis in five criminal justice system areas in July 2003 for national roll-out by December 2005. It aims to inform, protect and support witnesses better to increase witness attendance at court, improve trial outcomes and enhance witness satisfaction.

encouraged between Crown Prosecution Service caseworkers and Crown Court officers to ensure that the needs of child witnesses are identified and met.

6.23. Special measures have been developed to support witnesses who are children under 17 as well as for specific categories of adults [*ref.40* http://www.homeoffice.gov.uk/docs/yjceact.html]. These are particularly applicable in sexual offence and child abuse cases. Special measures include the video recording of the child's first interview, the giving of evidence over a TV link or behind a screen and the opportunity to meet court staff before the trial. Around 75% (approximately 4,500) of witnesses requiring special measures in 2003-04 were children.

6.24. Of the sample of cases[37] examined in which children were witnesses, appropriate special measures were being used in the majority of cases. However, inspection evidence shows that in some Areas potential eligibility for special measures is not being identified early enough in the process by the police, and in some cases it is not identified until the day of the trial itself. The NSPCC research also found that some children were afraid of being seen by the defendant or the public gallery over the TV link, but arrangements were rarely made to meet their concerns [*ref.39* http://www.nspcc.org.uk/inform/Research/Summaries/InTheirOwnWords.asp]. The Crown Prosecution Service does not currently gather or analyse data to investigate links between the use of special measures and successful case outcomes. Also, in the cases examined, appropriate letters to children under the Direct Communication with Victims scheme[38] were not sent in all relevant cases.

Good practice

North Yorkshire Crown Prosecution Service Area has prepared desk top instructions to assist in the preparation of applications for special measures. These include sample forms and guidance for their completion. Training has also been provided for lawyers and caseworkers specialising in dealing with cases involving vulnerable witnesses, including children.

[HMCPSI]

[37] Targeted sample of 353 CPS cases examined by HM Crown Prosecution Service Inspectorate, 2002-2004. There were 225 child abuse and 8 domestic violence cases in which children were witnesses.

[38] A Crown Prosecution Service scheme introduced in October 2002, under which it communicates any decision to drop or substantially alter a charge directly to the victim rather than via the police, giving as much detail as possible of the reasons. In cases involving a death, child abuse, sexual offences or racially/religiously aggravated offences, or where the reviewing lawyer considers it appropriate, a meeting is offered if further explanation is required.

CHILDREN AND YOUNG PEOPLE WHO COMMIT OFFENCES

6.25. Children and young people who commit offences present particular challenges for safeguarding. In July 2004, there were 2,746 young people in custody[39]. In 2003, young people were sentenced in around 24,500 cases in youth or magistrates' courts and in around 1,500 cases at the Crown Court[40].

6.26. The youth justice system has developed significantly in recent years. The establishment of the Youth Justice Board and youth offending teams has given greater emphasis to reducing crime through early intervention to prevent and tackle offending behaviour. This is based on the view that diverting children and young people who have committed minor crimes away from prosecution and into appropriate remedial services is ultimately more beneficial. This is supported by a wider range of sanctions now available outside the court system. They include acceptable behaviour contracts, anti-social behaviour orders, child curfews and child safety orders. There are also schemes, such as Drug Treatment and Testing Orders[41], and multi-agency work to divert children and young people who misuse drugs into treatment and break the link between drug misuse and crime. This is an important recognition of the safeguarding issues involved in substance misuse. However, the preventive approach may sometimes be incongruous with the Criminal Justice System's parallel focus on, and associated target for, bringing to justice[42] children and young people who commit offences.

6.27. This section focuses principally on the contribution of youth offending teams to safeguarding children and young people who commit offences, since they play an important role in taking an overview from apprehension for the alleged offence to sentence and beyond. Every council with social services and education responsibilities has set up a youth offending team to help prevent offending by children and young people. The multi-disciplinary teams include probation officers, police officers, social workers and health and education staff.

6.28. The first *Safeguarding Children* report found that in focusing on offending behaviour, youth offending teams were not always giving sufficient emphasis to the wider protection and safeguarding needs of young people. HMI Probation looked in detail at the safeguarding work of five youth offending teams in England and carried out a questionnaire survey of the others [*ref.41* http://www.homeoffice.gov.uk/justice/probation/inspprob/thematiccurrent.html].

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[39] Youth Justice Board statistics.
[40] Crown Prosecution Service statistics.
[41] The Drug Treatment and Testing Order was introduced in the Crime and Disorder Act 1998 and made available to all courts in England and Wales from 2000. Offenders must submit to drug testing, attend intensive treatment and rehabilitation and have their progress regularly reviewed by the court. It complements other interventions within the criminal justice system aimed at targeting treatment to drug misusers.
[42] The Narrowing the Justice Gap target is a key priority for Local Criminal Justice Boards, who are required to increase the number of offences brought to justice by 17% by 2005-06.

Information from core YOT inspections, as well as inspection work with the Crown Prosecution Service and courts service is also included in this section.

Making safeguarding a priority

6.29. Youth offending teams have responded positively to the findings in the first *Safeguarding Children* report and are now giving greater recognition to safeguarding issues, particularly at a senior level. The challenge is to embed this commitment into practice. Staff often commented on the need for national guidance on good practice in safeguarding. Nearly two thirds of teams say they have policies addressing specific safeguards issues, while a third say they are incorporated into other policies. Only six youth offending teams have no such material. However, diversity issues, disability and special needs are not given sufficient emphasis overall. Youth offending teams are maturing organisations and monitoring and evaluation are still developing. This makes the role of operational managers in their oversight of cases particularly important.

6.30. Questionnaire surveys[43] show that children are almost exclusively positive about their experiences with youth offending teams. 89% (114) of children said their worker sometimes or always talked to them in a way they could understand, while 94% (120) said they felt listened to. 83% (106) of children said they were always treated fairly and with respect. However, the existence or accessibility of complaints procedures is more variable.

> *'I get to talk to someone who treats me like an adult and with respect… They are interesting and I learn a lot about myself and how to stay out of trouble…I learn about offending behaviour and finding out it gets you nowhere.'* [*ref.42* http://www.youth-justice-board.gov.uk/NR/rdonlyres/7AC02307-02B0-4B9B-BFCB-FF5EE0763112/0/HMIPYotReport2004.pdf]

6.31. The first *Safeguarding Children* report found that youth offending teams were detached from other services. It is therefore encouraging that they now view relationships with their key partners as a strength and have a much higher profile on ACPCs. However, there is some uncertainty among youth offending teams about their role on the new Local Safeguarding Children Boards. Furthermore, only half of them have information sharing protocols with other agencies that cover safeguards issues.

[43] Interactive questionnaires completed by 128 children and young people, administered by the joint inspection team as part of overall YOTs inspections. The results should be read as indicative rather than representative.

Good practice

Strong relationships between North Tyneside Youth Offending Team and social services were reported during inspections. This includes a protocol with social services in relation to looked after children, court work and remands to council accommodation. In the cases sampled, social services were always involved during the supervision period for looked after children and those considered vulnerable from self-harm. Difficulties in relation to the placement of children and young people in local accommodation were actively being addressed. There were also effective arrangements for information sharing between the Courts and the Youth Offending Team: Youth Offending Team Court Officers have access to an office and a networked terminal in the Courts so that Court Orders can be processed quickly.

[HMI Probation]

6.32. It is of concern that 10% of youth offending teams still have employees and volunteers who have not been CRB checked, reflecting a common theme. There is also a lack of formal supervision arrangements for Appropriate Adults[44].

Safeguarding in custody

6.33. Where young people are taken into police custody, they need information about the services available to them and what they can expect to happen, for example about legal advice and court processes. Not all youth offending teams are providing such information consistently. Appropriate Adults are generally considered to provide an invaluable service, but some parents are not adequately or promptly informed about the outcome of an interview. There is also a lack of clarity with the police about the time of day or night when Appropriate Adults can be called upon to attend interviews. Recording practice needs improvement to demonstrate consistently the work that Appropriate Adults carry out at police stations. For example, in interviews, Appropriate Adults emphasised that they always check whether young people are informed in all cases of their right to legal assistance, but did not always record that they had done so.

6.34. The management of young people following their appearance at a police station raises concerns. The scarcity of council remand placements is a factor in some young people being detained inappropriately overnight in police cells. Some Appropriate Adults feel that insufficient attention is paid by social services to young people discharged with no accommodation to go to. There is also uncertainty about responsibility for ensuring a discharged young person gets home safely and for providing appropriate clothing when his or her own clothes are kept for forensic examination.

[44] Appropriate Adults are volunteers who can be called upon to attend interviews of young people in police custody when parents or carers cannot be contacted.

Safeguarding in court

6.35. Young people charged with offences usually appear at a youth court where they are bailed or remanded in custody. The courts generally indicate that youth offending teams provide an excellent service. However, youth offending teams rely on the police to notify them of a young person's appearance in court. Also, it is sometimes difficult for them to provide a presence at weekend courts. Youth offending teams may not always highlight adequately a young person's safeguarding needs at the point of bail. Bail ASSETS[45] (an assessment of the young person's suitability for bail) were completed at the young person's first court appearance in only 48% of cases inspected. Of the completed Bail ASSETs, only 55% of relevant cases where there were substantive safeguards issues were considered to be sensitive to those issues, for example if the young person was at risk from other people or from self-harm.

Good practice

At Enfield Youth Offending Team, staff meet with children and young people and their parents or carers following an appearance at court. This provides the opportunity to assess the needs of the child or young person in relation to health or substance misuse. The information obtained is passed to a case manager and helps to facilitate future meetings with the child or young person and parents or carers.

[HMI Probation]

6.36. In most cases, interventions in practice are more positive and two thirds took account of safeguarding. However, there are difficulties in providing services in some areas, including access to and provision of mental health services. This is of concern, since some 45% of all cases examined as part of the core youth offending teams inspection, covering children aged 10-17, have had emotional or mental health problems. The majority of youth offending teams' pre-sentence reports appropriately address safeguarding issues, particularly the suitability or otherwise of custody. However, gender, religious and ethnicity issues are less well covered.

6.37. Although cases involving children and young people who commit offences are normally heard in the youth courts, if a young person is charged with a grave offence, the case may be committed to the Crown Court. Evidence shows that magistrates' courts are proactive in handling youth cases in accordance with accepted good practice. This includes the separation, wherever possible, of young defendants and witnesses from those attending adult courts. The handling of youth cases has increasingly become a recognised area of expertise, with significant investment in the training of magistrates and legal advisers. Inspections of Crown Prosecution Service Areas show that trials of children and young people who commit offences are in most cases well handled by specialist

[45] An assessment tool developed by the Youth Justice Board.

youth prosecutors and that efforts are made to prioritise and expedite such cases. Where agents are used for youth trials instead of Crown Prosecution Service prosecutors, however, there is sometimes concern about their level of experience in dealing with youth cases. The majority of Criminal Justice System Areas now regularly achieve the national target aimed at reducing the time from arrest to sentence for persistent young offenders[46].

Safeguarding on remand

6.38. Where young people are subject to remand, arrangements between agencies need clarification. There is often confusion about who should complete the necessary paperwork when a young person is remanded into the care of the council. Inspections found that a third of the required paperwork was not being completed. For secure remands, youth offending teams are following guidance on placements, keeping parents and carers informed and making considerable efforts to ensure that staff in secure facilities are aware of a young person's vulnerability. However, there are some examples of young people remanded to prison custody who remained there until sentence, with no input from the youth offending team.

6.39. There is also a lack of clarity about responsibility for a young person during the period between remand and escort to a secure establishment, which can be several hours. There is an absence of formal guidelines or legislation on this point, but there are examples of local arrangements to address it.

Good practice

Oxfordshire Youth Offending Team's Custody Manager provides briefings to young people at risk of remand to custody and their parent(s)/carer(s), where they can ask questions about what their children could expect.

[HMI Probation]

6.40. As noted in chapter 5, young people remanded to prison custody are particularly vulnerable on arrival and immediately thereafter. This emphasises the importance of the initial planning meeting in identifying the young person's needs. It is not always logistically possible for youth offending teams to be present at these meetings and there is not always evidence that the young person's needs have been taken fully into account.

[46] In 1996, the Government pledged to halve the average time from arrest to sentence for persistent young offenders from 142 days to 71 days. In November 2004, the average time from arrest to sentence was 65 days (England and Wales).

CONCLUSIONS

6.41. This review found that the justice system agencies covered in the inspection work for the first *Safeguarding Children* report were found to be giving greater priority to safeguarding. For example, in 2002, youth offending teams were found to be detached from other services and not giving sufficient attention to the wider safeguarding and protection needs of children and young people who commit offences. They are now giving much greater recognition to safeguarding issues. Other agencies, including CAFCASS, the courts and the Crown Prosecution Service, have elements of good safeguarding policy and practice. In addition, child abuse and domestic violence cases involving children as victims or witnesses are generally well handled and consideration is given to the safeguarding needs of these children.

6.42. The creation of a unified courts service, unified inspection arrangements and Local Family Justice Boards provides an opportunity to improve still further the priority given to safeguarding children. Key areas for improvement include:

- determining what safeguarding children means in the context of the justice system;
- bringing together existing elements of safeguarding policy and practice into overarching strategies in the Crown Prosecution Service, CAFCASS and the courts;
- involving children more widely in family proceedings so that they have a greater say in the formal arrangements that will significantly affect their lives;
- ensuring that early opportunities that are appropriate to the individual children concerned are taken to protect and support all children who are victims or witnesses; and
- clarifying roles and responsibilities between youth offending teams and other agencies at key points, including when a young person has been in police custody, has been remanded into the care of the council or has been remanded in custody to a secure setting.

7. CHILDREN SEEKING ASYLUM

INTRODUCTION

7.1. The first *Safeguarding Children* report identified children seeking asylum as a subject for further examination. It recommended that inspection work should be carried out on safeguarding arrangements for unaccompanied asylum-seeking children and the children of refugees and asylum seekers. This chapter includes evidence from:

- a review of five councils: two London boroughs and three councils outside London, which have received large numbers of asylum-seeking families with children since the National Asylum Support Service (NASS) dispersal scheme was set up in 2000;

- CSCI's Children's Services Inspections, inspections of youth offending teams and Ofsted inspections of the education of asylum-seeking children; and

- recent publications and additional discussions with social services managers involved in strategic planning and front-line services for asylum seekers.

7.2. This chapter also examines arrangements for children held with their families using evidence from HMI Prisons inspections of two immigration removal centres in England: Oakington (Cambridgeshire) and Tinsley House (West Sussex). The centre at Dungavel (South Lanarkshire) is outside the scope of this review, although asylum-seeking families based in England might be placed there pending deportation.

ASYLUM-SEEKING CHILDREN IN CONTEXT

7.3. People come from abroad to the UK for a variety of reasons. Some are children who have fled their home country to seek asylum. They arrive with one or both parents; with friends or relatives who are their usual carers; with an agent with whom an arrangement has been made; or are unaccompanied for many different reasons [*ref.49* http://www.savethechildren.org.uk/scuk/jsp/resources/details.jsp?id=247&group=resources§ion=publication&subsection=details&pagelang=en]. Some of these children lodge an application for asylum, either as part of their family or other group (accompanied children); or as an unaccompanied asylum-seeking child. Other children do not make an asylum application but this does not mean that they do not have needs: they are in a variety of circumstances, and some may be isolated, or living in unsafe settings. The lack of available information about the range of children involved raises considerable concern about safeguarding arrangements, and further work needs to be carried out to identify and plan for them. On the evidence available for this review, this chapter focuses on children

who have lodged an asylum claim, whether as accompanied or unaccompanied children.

7.4. Unaccompanied asylum-seeking children are the responsibility of the local council with social services responsibilities where they first present. In March 2004, councils were supporting around 7,800 children in total, of whom 76% (around 5,900) were aged 16-17. The origins of asylum seekers arriving in the UK reflect the international situation at any one time. In 2004, of the 2,755 asylum applications from unaccompanied children, the top five nationalities were Afghanistan (10% - 280), Iran (10% - 275), Somalia (9% - 245), Vietnam (7% - 180) and Eritrea (6% - 155)[47]. Because of the length of time that unaccompanied asylum-seeking children spend in the system, there are still a considerable number from previous trouble spots, such as the former Yugoslavia.

7.5. The majority of children arriving with their families present in London and Kent, near the main entry points to the UK, and in Croydon, where the Immigration and Nationality Directorate is based. From 2000 onwards, NASS dispersed asylum-seeker families needing accommodation to areas around the country where suitable housing was available, mainly in the Midlands and the north of England. The objective was 'to reduce the disproportionate burden on statutory services in London and the south east.' Around 9,830 families receive NASS support. Of these, 3,830 are families which preferred to maintain links with their communities and have remained in London and the south east on a subsistence only basis. Nationally, there are around 24,500 children under 16 seeking asylum. NASS supported around 64,500 asylum seekers in total in December 2004.

7.6. Under immigration law, the Immigration Service can detain people whom it plans to remove from the country. They are held in immigration removal centres. Periods of detention are often short in practice, but there is no time limit. Children may be detained as part of a family group, but unaccompanied children are not detained, although there are sometimes disputes about whether a young person is under 18 or not. The numbers of children who are detained with their families are small: there were a maximum of 75 at the time of the fieldwork. Inspections raised serious concerns about the welfare of detained children, who have not been given enough attention either in the national framework or in local safeguarding arrangements. These issues are considered in detail in paragraphs 7.27 – 7.36.

STRATEGIC PLANNING FOR ASYLUM-SEEKING CHILDREN

7.7. Commissioning of age and culturally appropriate services for asylum-seeking children is a highly complex and challenging task, affected by many factors often outside the control of individual agencies. This section reviews

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[47] IRSS statistics, January-December 2004. Applications from unaccompanied asylum-seeking children represented 8% of the total number of applications in 2004.

some of those issues including immigration policy and legislation; funding; cultural needs; health issues, including mental health; and information sharing about families and individual children.

Policy and legislation

7.8. Immigration legislation and duties under the Children Acts 1989 and 2004 are not easily reconciled, since immigration controls take precedence over welfare considerations. The government is a signatory to the United Nations Convention on the Rights of the Child 1989 and seeks to adhere to the Convention in the formulation of policy affecting children and young people. However, it also has a reservation for the purpose of immigration control. Furthermore, not all the duties within the Children Act 2004 extend to the Immigration and Nationality Directorate, and this affects agencies' ability to ensure that safeguards are taken into account in service decisions involving children and their families. For example, recent legislation[48] will require the withdrawal of entitlement to support for families whose asylum claims have been refused and who have failed to leave the UK voluntarily. Social services may only be able to offer support to the child if accommodated apart from their family, in contravention of the Children Act principle that children are best cared for within their families. However, there are some safeguards built into this system: the assessment of needs must consider whether human rights legislation would apply in any individual case.

7.9. The Immigration and Nationality Directorate, in recognition of their lack of experience in childcare issues, have now established a Taskforce to specifically address safeguarding issues. This Taskforce is supported by a group of expert advisers to assist in developing childcare and child protection policy and practice.

7.10. Most unaccompanied asylum-seeking children are granted discretionary leave, either for 3 years or up to their 18th birthday, or for 12 months if they come from a particular country. These concessions cease at age 18. The Association of Directors of Social Services therefore advocates that social workers and personal advisers should apply a 'twin-track' approach to pathway planning for every eventuality, including a potential decision to remove the young person from the country[49].

Funding

7.11. Unaccompanied asylum-seeking children receive a range of council services and there are complex funding arrangements. Councils are eligible for

[48] S9 of the Asylum and Immigration Act 2004.
[49] Association of Directors of Social Services Asylum Task Force, *Key Transitions for Unaccompanied Asylum-seeking Children: Guidance for social workers, personal advisers and their managers working with unaccompanied children*, in draft, December 2004.

reimbursement for direct care and support to unaccompanied asylum-seeking children, through a grant provided through NASS. However, because claims are made in retrospect, there is uncertainty about whether additional costs will be met and it is difficult to anticipate numbers needing services. Strategic planning of services is harder for this group of children than for others. Some councils and NASS also differ in their view about the levels of services that should be provided within normal funding allocations or grant-funded.

7.12. The Hillingdon judgment confirmed legislation and guidance on councils' responsibilities to unaccompanied asylum-seeking children, clarifying that they should provide support to these children based on a thorough assessment of their needs [*refs.43* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/LocalAuthorityCirculars/AllLocalAuthorityCirculars/LocalAuthorityCircularsArticle/fs/en?CONTENT_ID=4003946&chk=kx09kw,*44* http://www.lawreports.co.uk/qbaugc0.2.htm,*45* http://www.hmso.gov.uk/acts/en2000/20000035.htm]. A number of 16-17 year old unaccompanied asylum-seeking children had previously been categorised as receiving assistance under S.17 of the Children Act 1989, and consequently received support falling short of the provision of accommodation. The implications of the judgment were that they should be regarded instead as being accommodated as looked after children under S. 20. They would therefore be eligible to receive appropriate leaving care support post-18, including subsistence support to undertake further and higher education courses for those with leave to remain. A grant from the Department for Education and Skills is made as a contribution to the costs of additional care-leavers arising as a result of the Hillingdon judgment. The grant is triggered when the numbers of unaccompanied asylum seeker care leavers are more than 44 (full time equivalent). This grant is not attached to individuals, so can be used for areas of greatest need. The grant was paid for the first time in 2004/05, and future grant levels are being reviewed.

Cultural needs

7.13. Meeting children's cultural needs poses considerable challenges, particularly finding suitable foster-care placements in areas where there is no existing community of the relevant ethnic group. Councils and agencies in London and the south east have experience of working with diverse communities and highly mobile populations. Other large cities also have well-established ethnic minorities and refugee groups. However, some councils in the dispersal areas lacked such experience and had under-estimated the range and levels of support needed to develop their experience in meeting those needs more recently. Conversely, some councils in London and the south east have set up services that may now be under-utilised because of changing population needs. Asylum-seekers who have been dispersed are often subjected to racial discrimination from local communities, whether white or black, and minority ethnic communities.

Information

7.14. NASS routinely informs each LEA and primary care trust about new NASS cases in their area. It also funds enabling officers in each regional consortium to co-ordinate the response of the relevant agencies. However, many councils do not have a full picture of the numbers of unaccompanied asylum-seeking children in their areas because other placing councils sometimes fail to notify them. Also, information about individual asylum-seeking children, including welfare and health needs, is often scarce.

Good practice

The national pilot of the Safe Case Transfer project, funded by the Home Office, and led by Manchester City Council, is enabling participating local authorities to take over support of 16 & 17 year old asylum seekers transferred from Kent to Greater Manchester. The transfer and placement of young people will be made through a carefully planned and managed process based on detailed assessment of need. This will ensure appropriate support and safeguards for this potentially vulnerable group. CSCI/Ofsted

7.15. A particular safeguarding issue for unaccompanied asylum-seeking children is that of their true age. Where a young person's age is not clear, social workers must carry out an age assessment. Determining age is not an exact science, especially in cases where a child's growth or development might have been affected by social and medical factors. There are therefore risks, for example, in placing young people together if one is much older than stated. It is also important not to place young people together from different sects or ethnic backgrounds who may be in conflict in their home country.

Good practice

The National Register of Unaccompanied Children was set up by the London Asylum Seekers Consortium and NASS, with funding and support from the Home Office and the Department for Education and Skills. Secure website access allows the responsible council or the council covering the area where children are placed to find out about the whereabouts of all these children. Councils can also post information about children they are worried about. The Association of Directors of Social Services, the Association of Local Government and the London Asylum Seekers Consortium are on the project board. CSCI/Ofsted

7.16. Identifying where children are in private fostering situations, rather than with their own families, is also a problem that raises important safeguarding issues. Agencies sometimes fail to recognise that a child is privately fostered or insufficiently question claims that a child is closely related to the people he or she is living with, and consequently fail to alert social services to the situation. As paragraph 7.3 highlighted, some children or young people could therefore be living in situations where they are at extreme risk. This is also an issue for some

children in immigration removal centres who are accompanied by an adult who is not part of their family. From July 2005, National Minimum Standards for private fostering will be introduced. Local councils' performance against these standards will be subject to inspection. The National Minimum Standards, along with new measures on private fostering in the Children Act 2004 and replacement private fostering regulations which will come into force at the same time, will focus local council's attention on private fostering and require them to take a more proactive approach to identifying arrangements in their area. It is expected that they will improve notification rates and compliance with the existing legislative framework for private fostering.

ASYLUM-SEEKING CHILDREN IN THE COMMUNITY

Making safeguarding a priority

7.17. Overall, there is strong commitment in all the councils visited to safeguarding asylum-seeking children. Councils' policies promote children's rights and there are robust procedures for child welfare and protection. The majority of unaccompanied asylum-seeking children are looked after, and so have the same safeguards and benefits as other looked after children. Some councils have developed policy and guidance on inter-agency protocols for safeguarding children from abroad.

7.18. However, the quality and levels of inter-agency planning and co-ordination of services are very inconsistent and, in some areas, health services are not sufficiently involved. Some good work is being carried out by voluntary sector organisations with asylum-seeking children but it is not always well co-ordinated with work by councils and other statutory organisations. There is a need for improved joint working arrangements with community organisations, including churches and mosques, since some children and young people may not otherwise come to the attention of public services.

7.19. Information sharing about and identification of asylum seekers and other mobile sectors of the population are particularly inconsistent. Some councils are placing homeless families, who are sometimes overstayers, in other council areas without notifying the receiving council. Families 'disappear', sometimes moving of their own accord, and their onward destination is not ascertained. This means that some children in need of safeguarding may be slipping through the net. However, where LEAs use their ethnic minority achievement teams well, databases allow successful monitoring of the mobility of some asylum-seeking children as well as of their educational achievement. The planned role of an information sharing index system (see paragraph 5.63) and also the National Register of Unaccompanied Children will assist in identifying children or groups who may otherwise disappear from view.

Good practice

The London Borough of Newham has made a Neighbourhood Renewal Fund bid to enable the authority to focus on 100 children who have disappeared (the majority of whom are likely to be asylum seekers). These have been identified by youth offending teams, because they are previously unknown young people coming into the justice system, or health services, following incidents of self-harm or attempted suicide.

[CSCI/Ofsted]

Assessing and meeting needs

7.20. Assessing the needs of children seeking asylum is a complex process, often restricted by a lack of available information about the child, especially when he or she is unaccompanied. Only unaccompanied asylum seeking children receive a formal assessment, or children who have been brought to a council's attention for other reasons. NASS contracts for placing families do not provide for an automatic assessment of the needs of children who are with their families, although NASS has published guidance about referring concerns appropriately. The Home Office is currently considering a bid to establish social work teams in council areas covering the main entry points to the UK to ensure speedier assessments to meet needs and to identify children in need. A pilot assessment team is currently operating at the Immigration and Nationality Directorate's offices in Croydon and Dover.

7.21. Assessment is more comprehensive where unaccompanied asylum-seeking children are referred to specialist social work teams. These teams carry out effective holistic assessments and link children to the services they need, such as health care services. The range of agencies working with adults and families can be too far removed from social work services and may not always refer children for assessments of need or possibly child protection concerns, where necessary.

7.22. When their child protection needs are recognised, asylum-seeking children are dealt with equally well as other children. However, there is doubt about whether all concerns are adequately identified, including whether children are subject to trafficking for sexual exploitation or under-age girls are kidnapped for forced marriage. These risks are likely to be greatest for children who are in the country illegally and who are not formally known to statutory agencies. There are some good practice examples, such as a specialist child protection adviser for asylum-seeking children in one council. But it is often difficult to pin down the evidence of abuse and some councils are less familiar with the issues than others.

7.23. Unaccompanied asylum-seeking children are often older than most looked after children and are therefore placed in a residential home or are in independent living with support rather than in foster care. Where fostering is

considered appropriate, some councils experience considerable difficulties finding foster carers to address unaccompanied children's ethnic, religious, cultural and linguistic needs. This is particularly so when there is a sudden influx of children from a country that has previously provided few immigrants or where a particular ethnic community is located a long way from the area of the responsible council. Some councils have put considerable effort into recruiting and developing a network of foster carers from particular communities where there has been significant demand for placements. Other councils are providing mentors to support young people over 18 to care for younger relatives or others, matching carers by religion and providing links to community resources for the child and carers. Some asylum seeking young people reject potentially helpful matched placements as they have been advised by family or agents to be placed with an English speaking white family.

Good practice

The London Borough of Hillingdon experienced high demand for placements of unaccompanied children from the Horn of Africa and Afghanistan. The Fostering Team targeted the recruitment of foster carers from these communities, by advertising in local community press and by word of mouth. 14 carers from Eritrea and two from Afghanistan have been recruited over a period of several years. Fewer children are now arriving from the Horn of Africa and many have moved on to independent living, but these carers' considerable experience is being put to use for other unaccompanied children.

[CSCI]

7.24. Some councils are still not always adhering to legislation and guidance as clarified by the Hillingdon judgment [refs.*43,* http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/LocalAuthorityCirculars/AllLocalAuthorityCirculars/LocalAuthorityCircularsArticle/fs/en?CONTENT_ID=4003946&chk=kx09kw,*44* http://www.lawreports.co.uk/qbaugc0.2.htm,*45* http://www.hmso.gov.uk/acts/en2000/20000035.htm]. Unaccompanied asylum-seeking children under 16 generally receive a good service, but unaccompanied young people over 16 are sometimes placed in lodgings or bed and breakfast and are not allocated a social worker but dealt with by the duty officer. There is also evidence that some social services are placing looked after unaccompanied asylum-seeking children in other council areas without notification. As with all looked after children placed out of area, this puts them at risk of poor support and safeguarding. Services provided to unaccompanied asylum-seeking children preparing to leave care are generally good. Support for over-18s who were not previously treated as looked after children is less consistent.

Good practice

The London Borough of Hillingdon has a dedicated residential unit for unaccompanied asylum-seeking young people. The unit specialises in supporting them to prepare for independent living. There is a diverse team of