Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

HM Inspectorate of Probation
Arolygiaeth Prawf EM

Looked After Children:

An inspection of the work of Youth Offending Teams with children and young people who are looked after and placed away from home

A Joint Inspection by
HMI Probation, Ofsted and Estyn

December 2012

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

Looked After Children: An inspection of the work of Youth Offending Teams with children and young people who are looked after and placed away from home.

A Joint Inspection by HMI Probation, Ofsted and Estyn

ISBN: 978-1-84099-584-8

December 2012

Acknowledgements

We are grateful to Youth Offending Teams and Services in Blackpool; Halton & Warrington; Shropshire, Telford & Wrekin; Somerset; West London; and Wrexham and other partners that worked with them for their assistance with this inspection. Their willingness to engage with the inspection process ensured that we were able to gather the material we needed.

We would also like to thank HM Inspectorate of Prisons and the Care Quality Commission for their advice, Newham YOT for helping us to pilot the inspection and the agencies and individuals who contributed their time and knowledge including the youth offending services in Bournemouth and Poole, Cambridgeshire and Essex.

Lead Inspector	*Jane Attwood*
HMI Probation Inspectors	*Yvonne McGuckian; Tony Rolley*
HMI Practice Assessor	*Dave Cohen*
Ofsted Inspector	*Matthew Brazier*
Estyn Inspector	*Rachael Bubalo*
Support Staff	*Stephen Hunt; Oliver Kenton*
Publications Team	*Alex Pentecost; Christopher Reeves*
Editor	*Andy Smith*

Foreword

Children and young people who are in care, have offended and are accommodated away from their home area are a small, yet highly vulnerable group. They present challenges to those agencies responsible for their care and for helping them to avoid future offending. In this inspection we sought to find out how effectively Youth Offending Teams worked with this group and how well they planned and coordinated their work with colleagues in other agencies.

The findings of the inspection show that, despite the hard work and effort of many, the overall outcomes and future life chances for these children and young people are extremely poor and their individual stories make distressing reading. It was often difficult to see from the assessments why many were placed away from their home locality. Information sharing between children's social care services and Youth Offending Teams needed to improve. Although Youth Offending Team staff worked hard to develop good relationships with these children and young people and to deliver constructive interventions, many failed to appreciate fully the emotional impact of being looked after and in residential care.

We found that being in care often meant that children and young people were brought into the criminal justice system at an earlier point than those who were not looked after. It was disappointing that many had received their first court disposal whilst subject to local authority care.

The aspirations that many workers, across all services, had for Looked After Children were often woefully low; the fact that they were away from their home areas and were moved frequently militated against their chances of rehabilitation. Their lives were fragmented; links with family and friends were often disrupted, as were their education and training opportunities.

These children and young people are, in many cases, picked up in later life by either the criminal justice system or mental health services. It is clear from this inspection, that for many, their backgrounds and experiences in care meant that they were ill-equipped to lead happy, law-abiding and productive lives as adults in the future. In order for this to alter there needs to be significant change in policy and practice.

Liz Calderbank
HM Chief Inspector of Probation

Sir Michael Wilshaw
HM Chief Inspector of Education, Children's Services and Skills

Ann Keane
HM Chief Inspector of Education and Training in Wales

Contents

Summary

The Inspection

The inspection of children and young people who are looked after, placed away from home and supervised by YOTs was agreed by the Criminal Justice Chief Inspectors' Group, as part of the *Joint Inspection Business Plan 2010-2012*. It was led by HM Inspectorate of Probation, with support from Ofsted and Estyn. Its purpose was to assess the effectiveness of YOT work with this group of children and young people in promoting their rehabilitation and maintaining their links with their family and home area (where appropriate) and to identify barriers to effective YOT work.

We visited six areas where we asked the YOT to identify, where possible, ten cases, five of which they were supervising on behalf of other local authorities and five of their own cases being supervised by other YOTs. We then assessed the quality of joint work carried out by the agencies involved. The data was supplemented by information gathered from a number of YOTs which were not part of the main fieldwork.

Overall findings

This inspection looked at a very specific group of children and young people, who are looked after, who were placed away from home and also subject to supervision by YOTs. This group is extremely vulnerable. Some also pose a high risk of causing harm to others, not least the children and young people with whom they are placed.

Concerns had been raised about these children and young people by many of the YOTs we visited during our regular inspection programme of YOT work, particularly those located in areas with a high number of children's homes. From them we heard about lack of contact by home areas, delays in receipt of information about vulnerability and risk posed to others and difficulties in communication between agencies. This significantly impacted on the work by the host YOT to help children and young people to stop offending.

This thematic inspection clearly revealed the fragmentation of these children's lives and how the fact of being looked after could escalate a child or young person into the criminal justice system. It also showed how the two factors - being in care and offending – exacerbated each other.

Many of the children and young people whose cases we examined during the course of our inspection had been placed in a succession of children's homes. It was difficult to track them precisely, but we saw one young person with 31 placements and one placement that lasted less than 24 hours. Nearly one-third had had more than three placements outside their home area and 18% had had more than five (that were recorded); 63% were living more than 50 miles from their home and 24% more than 100 miles. (Regulations stipulate that, where reasonably practicable, placement should be within the home local authority area and as near to the child or young person's home as possible). Four-fifths of those in the sample had been moved during the period of YOT supervision and one-quarter being moved more than three times.

It was evident that the children and young people in our sample were amongst the most damaged and difficult to place. All had experienced considerable family difficulties, and they continued to struggle with the consequences. We found a significant number had been subjected to abuse - sexual, physical and emotional and/or neglect. Many had witnessed, or

been the victims of domestic violence. A high number had emotional or mental health problems.

Nevertheless, it was not apparent in many cases, from our inspection of YOT work, how the needs of the child were being promoted or safeguarded by a placement so far away from their home area. A significant number were still in contact with their families and continued to drift back to them, whether or not children's social care services promoted or even allowed contact. In 55% of cases YOTs worked actively with the child or young person's parent/carer to maintain contact.

In most cases, the breakdown in family relationships was further exacerbated by the frequency of changes in the professional relationships the child or young person was required to make, through social workers moving on, placements changing, disrupted education and different specialist agencies being called in.

Key Findings

Outcomes

In the overwhelming majority of the cases that we inspected, the outcomes for the children and young people were poor. Children and young people were not always protected. Some had been assaulted or sexually exploited; some had themselves assaulted or exploited other children and young people. They had often been criminalised while in care for offences that would probably not have gone to court if they had been living at home. A significant number had gone missing at some point, some a substantial number of times. Their education had suffered and few were well prepared or supported for transition to adulthood.

Youth offending work with children and young people who are looked after

For some YOTs the number of children and young people they are supervising from another local authority, puts a considerable strain on their resources. These 'host' YOTs told us that, at times, this group had constituted as many as 20% of their caseloads and that services to them, and to the local children and young people, suffered because their budgets did not reflect this. 'Home' YOTs (located in the local authority placing the child or young person) continued to have responsibility for some areas of work and the quality of this arrangement had a significant impact.

With the exception of residential key workers, the host YOT worker was often the person who had most contact with the child or young person. We saw some good joint work between YOTs including prompt allocation, good information sharing, sensible role allocation and sensitive, imaginative interventions. This was reflected in the views of the children and young people to whom we spoke who, almost universally, were very positive about their contact with host YOT workers.

Conversely, we also saw some duplication, some omission and a resultant impact on the service to the child or young person. Host YOTs were sometimes let down by late, inaccurate or insufficient information from the home YOT. In the worst case scenario, this meant that the risk of harm to others (other children and young people in the children's home and/or staff) was not managed or that vulnerability was not recognised. Where this happened, the host YOT was in a difficult position. If they refused to start work until they had the proper information, risk and vulnerability could go unmanaged and the court order was not

delivered. If they did start work, without the full facts, risk or vulnerability could be missed. Either way was unsatisfactory and, in our view, unnecessary.

A common issue, across the assessments we saw (by both home and host YOTs), was an apparent lack of understanding of the impact of being in care. We saw much information about the circumstances of coming into care, about placements and about behaviour. However there was little exploration, analysis or even acknowledgement of the impact on the emotional well-being of the child or young person or thought about how that needed to be addressed. Where it was understood, we saw YOT workers making an effort to engage children and young people, advocating on their behalf and recognising that their experiences needed to be taken into account in day-to-day interaction with them.

YOT work was not always fully understood, respected or valued by staff in other agencies. In some cases, this meant that offending behaviour was not given due weight leaving some children and young people, some residential staff and some of the wider public less protected than they might have been.

Working together

At a local authority level senior managers had to ensure that they discharged their duty towards children and young people placed out of area and make provision for children and young people who were placed in their own area by other local authorities. We found that for authorities with a significant number of children's homes in their areas this created pressure on resources. In addition, there was often an absence of information about residential provision and the number of children and young people who had been placed in children's home by other local authorities. We found that some local authorities had placed children and young people in establishments which had been deemed unsuitable by the local authority in which the home was located.

A small number of children and young people were placed in specialist therapeutic units, such as those which addressed sexually harmful behaviour. YOT and other staff working with these children and young people did not always have access to, or seek detailed information, about the content, quality and effectiveness of the interventions offered in these units.

The mix of children and young people from different local authorities in children's homes was a matter for concern, for example, the placement of young people who had committed sexually harmful behaviour in the same unit as victims of sexual abuse. The decision about which children and young people could live together was generally made by the placement provider; local authorities were very often not aware of the characteristics of the other residents.

The number of different staff involved with each child or young person makes effective joint working essential, particularly when they are being moved around the country. We found much individual hard work and commitment amongst the various professionals and managers working with these children and young people and we found instances of joint working that had produced benefits and improved outcomes.

We saw little longer-term planning and too many reactive decisions. In these circumstances, we were surprised that we did not see more challenge by Independent Reviewing Officers. It is their job to assess the quality and effectiveness of local authority planning and support for children and young people. They have a crucial role to play in ensuring that the local authority fulfils its responsibilities as a 'corporate parent'.

Each agency tended to follow its own procedures and worked to its own remit. We saw a number of cases where there had been a significant number of assessments from different disciplines, not all of them necessary in our view and often contradictory, resulting in little or no action or change.

Joint working quite often consisted of merely information sharing, often within formal meeting settings with one agency holding sway depending on the forum.

Children's social care services generally took precedence in the hierarchy of decision-making and did not always take account of the assessments and plans of other agencies. We were disappointed that Independent Reviewing Officers did not take a proactive role in ensuring that all agencies were working together and placing the child or young person at the centre of that effort.

Conclusion

This very specific group of children and young people are amongst the most damaged in the care system. By the time they are placed out of area it is likely that most will have had a number of placements fail. They are vulnerable and, in some cases, potentially dangerous. They need both protection and work to help them stop offending. At the same time, others may need to be protected from them. Work to engage, help and support them is difficult and is made significantly more so when they are moved around. While there is much commitment and hard work accorded them by YOT staff and others, agencies do not always work effectively together in the best interests of the child or young person. Despite the allocation of significant resources, they have poor initial and longer-term outcomes.

Recommendations

The Department for Education should ensure that:

- the regulations governing a child or young person's placement outside their local authority area are strengthened so that:
  - each placement of a child or young person outside the local authority area is authorised by a named senior person, and the reasons for the placement clearly recorded in the case record;
  - where such placements take place, relevant agencies in the receiving area are consulted and informed about the likely placement in advance of placement wherever possible.

Local authorities should ensure that:

- Independent Reviewing Officers ensure that all agencies work together to improve safeguarding outcomes for children and young people and share appropriate information, take account of each other's assessments, align plans for their long-term future and develop contingency arrangements where necessary;
- they satisfy themselves that specialist therapeutic interventions provided by residential placements are of good quality and suitable for the needs of children and young people.

Local Children's Safeguarding Boards should ensure that:

- data is collated, scrutinised and agencies held to account for improving safeguarding outcomes for children and young people who are looked after and placed outside their home area.

Youth Offending Team Managers should ensure that:

- accurate information about children and young people who are looked after and placed outside their home area is sent promptly to the YOT in the new area;
- assessments, intervention plans and reviews on children and young people take full account of the impact of being looked after;
- the enforcement processes for court orders and post-custodial licences are sensitive to, and take account of, the circumstances of children and young people who are looked after;
- action is taken, where appropriate, to increase the number of children and young people who are dealt with through restorative justice measures when they offend within the residential setting.

1. Scope and Purpose

Summary

This chapter outlines the inspection structure and methodology. It also provides a summary of the profile of the cases we inspected.

Key facts

- Over two-thirds of the children and young people in the sample were boys aged between 15 and 17.
- All except one were living in private children's homes or independently.

Background

1.1. This inspection was agreed by the Criminal Justice Chief Inspectors' Group following consultation with key stakeholders, as part of the *Joint Inspection Business Plan 2010-2012*. Its terms of reference were:

- to assess the effectiveness of YOT work with children and young people who are looked after, subject to supervision in the community and placed away from their home area in:
  - promoting their rehabilitation,
  - maintaining their links with their family and home area (where appropriate);
- to identify barriers to effective YOT work with this group.

1.2. There is little or no national or local outcome data that relates specifically to children and young people in care, who are also placed outside of their home authority, have offended and are in contact with youth offending services. The regular inspection of YOT work led by HMI Probation suggested that this specific group of children and young people appeared to be suffering particularly poor outcomes, often caused or exacerbated by the distance from home and a lack of joined-up working by the agencies involved with them.

Methodology

1.3. The inspection was led by HM Inspectorate of Probation, with support from Ofsted and Estyn. A set of criteria, informed by a scoping document was devised for the inspection based upon the existing policy and guidance relevant to the organisations inspected. The criteria for the inspection covered:

- leadership and partnership arrangements,
- assessment, planning and work with children and young people.

A case assessment tool was developed, piloted and refined prior to the inspection.

1.4. In order to assess policy and practice against the criteria, we visited six locations: Blackpool; Halton & Warrington; Shropshire, Telford & Wrekin; Somerset; West London and Wrexham. The choice of sites was informed by the number of children's homes in the area. Five of these had a concentration of children and young people who were placed in the area by outside local authorities. The sixth, in London, had very few children and young people placed there from outside of the area. Fieldwork was undertaken between January and March 2012.

1.5. In each location we asked the YOT to identify, where possible, ten cases, five of which they were supervising on behalf of other local authorities and five of their own cases being supervised by other YOTs. The data was supplemented by information gathered from a number of YOTs which were not part of the main fieldwork.

1.6. The 60 children and young people in our sample were:

- mainly boys (42 out of 60),
- aged between 11 and 18 years, the majority (67%) being between 15 and 17 years,
- living in either children's homes or independently (with one exception),
- under either a full or interim care order (43%) or in voluntary care (57%),
- mainly white British (78%); a further 8% were classified as black or black British,
- over half had been recorded as offending within the care environment and 11 children and young people had been victims themselves.

1.7. We read case records and interviewed YOT case managers, social workers and other staff directly involved with the child or young person. These included placement staff, external YOT workers, CAMHs staff, Independent Reviewing Officers (IRO) and others. We met with managers and senior managers from children's social care services and we spoke to children and young people. We also sought the views of national officers from statutory and voluntary organisations involved with children and young people who are looked after and within the criminal justice system.

2. Outcomes

Summary

This chapter describes how the initial outcomes for this group of children and young people are poor and that their future prospects are likely to be detrimentally affected. It comments on criminal justice, safeguarding, education and transition.

Key findings

- Over half of the children and young people had offended within the care environment and a similar proportion had offended whilst subject to supervision.
- Children and young people who were looked after out of area were not always adequately safeguarded.
- Over one-third of children and young people in the sample were placed more than 100 miles from home.
- Education outcomes were disappointing.
- Successful transition to adulthood is compromised by the disruption caused by frequent moves.

Context

2.1. It is known that outcomes for children and young people who are looked after are worse than for the general population. Care leavers are disproportionately represented in the prison system[1] and homeless population[2], they tend to have lower levels of educational participation and attainment[3] and are at higher risk of mental health problems[4]. Risk factors contributing to youth offending coincide in many cases with factors experienced by children and young people who are looked after. If children and young people in care do not have stable placements and appropriate professional support, they are at risk of offending[5].

2.2. When placing children and young people, regulations require local authorities, as far as reasonably practicable, to allow the child or young person to live near their home, within the local authority's area, not to disrupt their education and take account of the wishes of the child or young person. They are also required to provide sufficient accommodation within the authority's area to meet the needs of children and young people who are looked after, yet 2011 Department for Education data[6] concluded that:

- there were ten local authorities with no children's homes in their area,
- 29% of children and young people who were looked after in children's homes lived outside their own local authority and over 20 miles from home,
- 40 local authorities did not have sufficient children's home places in their area to meet their need for places,

- a total of 22 local authorities had spare capacity in the children's homes they provided, yet placed children outside their area,
- 91% of children placed outside the local authority were in private or voluntary provision,
- 71% of children placed inside the local authority boundary were in local authority provision,
- The maximum number of children's homes in one local authority area was 93 where others had none.

Criminal justice outcomes

2.3. Initial criminal justice outcomes for the children and young people in the case sample were disappointing. Of the 60 cases we inspected:

- a total of 31 children and young people had offended within the care environment,
- there was evidence of reoffending during the period of YOT supervision in 27 cases,
- ten children and young people had harmed other residents,
- in 34 cases the child or young person had not complied with the sentence of the court,
- sufficient progress had not been made on the factors that were assessed as offending related in 14 cases,
- restorative justice had been attempted with only four children and young people.

2.4. The Crown Prosecution Service (CPS) guidance[7] specifies that a criminal justice disposal should not be regarded as an automatic response to offending behaviour by a Looked After Child and monitoring the results of offending within children's homes is part of the Ofsted inspection regime for children's residential establishments. Despite this, the consensus view of practitioners was that in some instances the police action and court appearances were used as a way of imposing discipline in an attempt to manage behaviour within a residential setting. The result - a criminal record - has a lasting impact on an individual's life chances, at worst increasing the possibility that they will spend some time in a custodial environment with everything that entails and at best, damaging employment prospects. In one of the areas we visited, the chair of the magistrates' youth panel had written to the Local Government Association to raise this issue and pointed out that these concerns had been continually expressed by the Magistrates' Association.

2.5. Magistrates also told us that remand decisions and sentencing were made more difficult because the adult accompanying the child or young person to court was very rarely their social worker or even someone who knew them well. YOT staff told us that this had a detrimental impact on the decisions made in court, making the use of custody more difficult to avoid. In one case we saw, a young person was accompanied to court to face charges of assault against care staff by a member of staff whom she had previously assaulted.

Case example: criminalisation

Sadie was 15 years old and was taken into care in 2005 as the victim of sexual abuse. When she came into care she had no history of offending behaviour. Her (first and only) offence was the theft of a laptop and mobile phone from another resident in the children's home. There were no recorded attempts at a restorative justice approach and Sadie was charged with burglary and convicted.

One young man told us:

"*When I was 13 I was placed with much older kids in a care home. I started offending then as I had to fit in. I could not say no. I got a taste for it.*"

Safeguarding outcomes

2.6. While it might reasonably be expected that children and young people in care were, at the very least, being protected, that was not always the case. In two-thirds of the cases we inspected we judged that the child or young person had not been effectively safeguarded. This was largely because of insufficient assessment and/or planning. There is no national data to show how many children and young people have been victims themselves within children's homes or have hurt other residents or staff, however our inspection findings showed that this was occurring not infrequently.

2.7. Our findings indicated that the initial safeguarding outcomes for the children and young people in the case sample gave rise to concern:

- in one-fifth of cases children and young people had themselves been victims of crime whilst under the supervision of the YOT,
- less than half had had their emotional or mental health needs met,
- over three-quarters had more than one placement during the period of YOT supervision and nearly two-thirds were placed more than 50 miles away from home with over one-third more than 100 miles away without a clear explanation in many cases why these actions had been taken.

Not all safeguarding failures can be captured by statistics.

Case example: safeguarding

Alice was a thirteen year old girl who had been taken into care due to sexual exploitation. She had little contact with her mother who had moved abroad and had lived with her father. She was using drugs and had repeatedly self-harmed and run away. At the children's home, a fifteen year old boy was found having sex with her in her room and had sexual videos of her were found on his mobile phone.

One 16 year old girl told us:

"No one truly cares about me. They get paid to care but they don't really. If they did they would stop moving me about and understand me instead of talking about what my needs are."

2.8. Police and other professionals told us that children and young people who were placed outside their home area often ran away from placements and became missing persons, with all the risks to them that entailed. Unfortunately, formal data to corroborate this was not collated by agencies.

Stan was Welsh and had been in care since he was four years old as both parents had long-term heroin addiction. He had spent most of his time in care, in Wales, living near enough to his mother to enable him to have a relationship with her which he valued. When he was moved to England and too far away for this to continue, he was reported missing on 37 occasions in a four month period.

Education outcomes

2.9. Education was generally arranged by the residential placement, whether as home tutoring within the children's home, externally at a 'school' provided by the organisation or through the host local authority education provision.

2.10. Initial education outcomes for the children and young people in the case sample were poor and we judged that nearly half of the children in our inspection sample had had their education negatively affected as a result of their circumstances.

2.11. The ability to settle into education was affected when children and young people were moved. A significant amount of the education was activity based and we saw few reports of a curriculum involving GCSEs and none including A-levels. This had a longer-term negative impact on prospects for employment. In 46% of the inspected cases, YOT and education workers had not worked effectively together. The ability of YOT education staff to be involved was limited as education was generally provided by the placement and not through the local authority.

2.12. We did see one example of work to try to sustain educational provision and limit disruption:

Good practice example: education

Katie was moved to **Shropshire, Telford and Wrekin**, a long way from her school which was in another local authority. She wished to remain at the school and her care plan reflected that. The children's home staff facilitated her attendance by transporting her every day. She was doing well in attendance and behaviour.

Independence

2.13. We did not find any cases with longer-term plans by children's social care services for the future lives of the children and young people. We saw little evidence of any successful move to independent living in the cases we inspected although half were aged 16 or over. Instead, we saw some children and young people placed in specialist supported accommodation, some in bed and breakfast accommodation and some in hostels. These were often unregulated settings which offered few safeguards. Some had decided to go back to live with families from whom they had been removed several years earlier. Some were drifting around acquaintances. The preparation and the support available from children's social care services were inadequate in most cases.

2.14. Similarly, there was little evidence of any successful move into the world of work, much less further education. They had few strong connections to the geographical area and no long-term friends or links to any local groups or clubs. The isolation that resulted meant that they were more likely to gravitate to a peer group which reinforced the negative aspects of their lives.

Neil was taken into care when he was six years old. At 14 years old he lost his placement through offending within the children's home. Over the next three years he was moved 20 times; sometimes back to placements he had been in previously. At 17 years old, he was the father of a child and had already been convicted of one violent offence against his partner. He was using cocaine and owed money to drug dealers. He was living in independent, supported accommodation which also housed other drug users. He had no friends and was isolated and lonely.

What does it feel like?

2.15. National outcome data for children and young people who are looked after is available, as are general youth offending statistics. However, there is little or no national or local outcome data relating specifically to those who have been placed outside their home authority at any point. From the cases that we inspected, the indicators were that the outcomes were extremely poor and likely to be worse than for other groups within the looked after system.

2.16. What is less measurable is the distress that is integral to all of those factors. The individual stories of these children and young people were immensely sad. They revealed missed opportunities, blighted childhoods and wasted lives. The result was young adults with no close family or friendships, with no sense of belonging anywhere or to any community, with little hope of successful futures and, in crude terms, the prospect of being a long term burden on the health, welfare and criminal justice systems.

Mia, a 15 year old girl, had lost touch with all her family and friends within a few months of being taken into care. The only relationships she had were with professionals. She was so distressed when she was moved from one children's home to another that she attempted to walk back to the first which was over two hours away.

One young woman told us she had counted 27 workers in her life. Another told us:

"I have lost all my connections with people. I have been moved to three different schools and lost my friends. We don't know what to talk about as they have different things happening."

Conclusion

The initial outcomes for the group of children and young people in this inspection were extremely poor. Nor are they likely to be diverted from offending or reoffending by being in care. For those who have not offended previously, it may be that it increases the chances of criminalisation. Some children and young people can be at risk from others with whom they live and put themselves at risk by frequently running away. Whilst there cannot be any certainty that being a Looked After Child will secure a child or young person's safe

development, the potential for securing it should not be jeopardised by placing them far from their home area unless such a placement is necessary for their future well-being. Education is also disrupted, as are their links to community which ultimately makes transition to independence more difficult. Whilst there is no specific long-term data to confirm that their life chances are damaged, it seems very likely that their prospects are as poor as their initial outcomes.

3. Youth offending work with children and young people who are looked after

Summary

This section describes the work carried out by both home and host YOTs. It comments on the transfer of cases between YOTs, the quality of assessment, planning and interventions and the work to avoid criminalisation of children and young people.

Key findings

- For the YOTs with children's homes in their area there was a significant impact on their workload.
- Host YOTs had developed systems for managing the transfer of cases into their area.
- The delay in receipt of up-to-date, good quality information by host YOTs potentially compromised the service to children and young people, the management of the risk of harm that they posed to others and the success of their court orders.
- Host YOTs had good levels of contact and worked constructively with the children and young people.
- There was little acknowledgement or understanding of the impact of the child or young person's life experience or circumstances within YOT assessment processes.
- Children and young people within children's homes were not being diverted from the criminal justice system through the use of restorative justice.
- There was often a lack of understanding about the role of the YOT by other agencies involved with the child or young person under supervision.

YOT workload

3.1. The supervision of community sentences and post-custodial licences for children and young people who are looked after and placed outside their home area generally falls to the YOT in the local authority where they are resident. Some of the work remains the responsibility of the YOT in the local authority placing the child or young person for example, attending children's social care reviews and monitoring progress. Depending on the individual case, the home YOT may also maintain regular contact with parents/carers or making visits to the child or young person. In England, the Youth Justice Board provides guidance on the responsibilities of home and host YOTs and suggests the process for sharing information and joint working.[8] (The guidance had yet to be adopted in Wales.) In practice, host YOTs had often developed their own processes to try to manage the influx of work.

3.2. For some YOTs, work with this group of children and young people does not significantly impact upon their workload. For others it is a significant proportion of their caseload. The North West area had the most private and voluntary run homes (375) in England as at 30 September 2011, followed by the West Midlands (257).

Other regions of England and particular areas in Wales also had substantial numbers of private children's homes located in their area. This can impact on all local services but was particularly difficult for smaller services like YOTs. Funding is based on their local population hence this increase in workload had the potential to impact on their ability to deliver good quality services to all the children and young people they were working with, both those from their own local authority and those from outside.

3.3. Five of the six YOTs we visited were within areas with a significant number of children's homes in their area. All had developed processes to ensure that they obtained sufficient information to work safely and productively with the child or young person in their area. These were generally carried out by managers and inevitably these processes were time consuming. What managers found extremely frustrating was the extra, and what they considered *unnecessary,* amount of time taken up chasing information that should have come automatically, for example good quality, up-to-date assessments and plans.

3.4. When good quality information was not provided promptly it placed the host YOT in a difficult position. If they insisted on waiting for the information before commencing supervision, the child or young person did not get a service. However, if they did commence work with them, they were doing so without knowing what risk they posed, how vulnerable they were or what work needed to be done. Some YOTs were more stringent than others in insisting that information was provided before work could commence. Other YOTs started to work with children and young people whilst they continued to chase for information. Within the sample, 38% of cases had not been allocated promptly and in a third of those cases it was the lack of information from the home YOT that had delayed allocation.

3.5. In the main, we found that host YOTs we visited were working very hard to provide services but were hampered when home YOTs did not provide up to date information. It was not always easy to understand why this happened and it had sometimes produced conflict between the two YOTs.

Assessment and planning

3.6. We saw some good liaison between home and host YOTs and sensible role allocation between workers to provide specific services.

Good practice example: assessing individual need

Steve, a young man on a community order who was placed away from home in a children's home, had learning disabilities and was able to relate better to male workers.

The YOTs involved in the supervision – **Leeds** (home) and **Halton and Warrington** (host) carried out a joint interview and reversed their roles to take account of Steve's needs. The **Halton & Warrington** YOT officer (male) conducted the majority of the interview while the **Leeds** YOS officer (female) who was completing the assessment took notes and clarified points where necessary. This joined-up approach took into account his individual needs and ensured that the young person was able to engage with the assessment process.

3.7. However, in more than half the cases we inspected, the contact between the YOTs prior to placement was not sufficient. In nearly one-third of cases the host YOT was not aware of the child or young person being in the area until after they had moved.

Inevitably some of those instances where the move was the result of a placement breakdown and, in these emergencies, the home YOTs were not always immediately advised. The overall impact was however, that assessment and planning was often not of the required standard.

Cara, who was 13 years old, had been in and out of care for several years. Her offences were arson and assault, having attempted to set fire to a children's home and seriously hurt a care worker. The host YOT did not know Cara was in the area until two weeks after she arrived. It took the host YOT three weeks to obtain assessments and she was not seen until then (five weeks after arrival.). The assessments of the risk to other residents and staff were not made available to the placement until at least two weeks after she arrived. There were substantial risks to other children and young people living in the children's home with someone who had already attempted to set fire to one. In this case there were also serious risks to care workers; which were not communicated to the staff in the children's home and hence there were no specific plans or safeguards for them or the other residents were put in place.

3.8. We also found a small amount of unnecessary duplication which seemed to be about each YOT demonstrating involvement rather than effective joint working. For example, in one case, we saw separate assessments of vulnerability by the two YOTs which came out with different ratings. This was not helped by difficulties in transferring data across two databases – YOIS and Careworks. We were also told that on occasion there was data loss when transferring between the *same* databases.

3.9. We found limited understanding of the impact of the child or young person's life experiences. Some Asset assessments were more detailed than others and included numbers, dates and types of placement and reasons for coming into care. Some included information about family relationships. Very few contained an in-depth analysis of how any of this affected the child or young person and their behaviour. There was little mention of loss, disruption, loneliness or sadness and yet most of the life stories that we read were tragic. In some ways, this was the most disappointing aspect of our findings – the matter-of-fact way that some YOT workers seemed to accept the detail of the child or young person's life experience without any apparent understanding of the continuing impact.

3.10. Emotional and mental health was not sufficiently well assessed in nearly two-thirds of the cases in the sample. This was particularly concerning given the knowledge about the long-term mental health prospects for children and young people who are looked after; there were only eight cases where we judged this was not a factor. It seemed that most YOTs only considered this to be an issue if there was a diagnosed mental health condition rather than understanding the effect of the child or young person's life experience on their feelings and emotions.

3.11. There was a lack of active engagement by both home and host YOTs of children and young people and their parents/carers in both assessment and planning. In particular, nearly two-thirds of parents/carers (who were still involved with their children) had not been actively engaged in assessment. Half of supervision plans had been drawn up without the active engagement of either children or young people or their parents/carers.

3.12. We judged that diversity factors associated with being looked after had not been identified in over half of the cases in the sample. Poor behaviour, lack of engagement

or apparent defiance was often taken at face value with little interest shown or account taken of the emotional state of the child or young person. Very few supervision plans even alluded to this aspect of the child or young person's life. We saw none that took account of the settling in period at a new placement for instance. In over one-quarter of the cases, the care plan was not on file and hence could not be integrated into YOT plans. The lives and experiences of these children and young people meant that any constructive work to reduce reoffending was unlikely to have much impact unless YOT workers first understood, properly empathised and then engaged in an informed way with the child or young person.

Interventions

3.13. Despite our concerns about some aspects of the quality of assessment and planning, we judged that host YOTs provided a good service to children and young people in relation to a number of aspects of practice.

3.14. Consistent delivery of a programme of offending behaviour work was often difficult because of the upheaval in child or young person's life. Despite this purposeful visits to children's homes were carried out in 83% of cases. This was generally to meet with children and young people although, in some cases, offending behaviour work was carried out there.

3.15. Interventions to manage the risk of harm posed to others were delivered in nearly 80% of cases with over 90% of those considered to be of good quality and targeted at reducing reoffending. Work to safeguard the individual child or young person was also carried out in the vast majority of cases. On the whole, interventions took into account diversity factors. Host YOTs were particularly good at motivating and supporting children and young people. We saw some imaginative work which took into account individual need. For example, one worker had completed work on the geography of the child or young person's placement so that they had some idea of where they were in the country in relation to their home.

3.16. Services from home YOTs were less consistent in their quality. In half of the cases, home YOTs had not carried out purposeful visits or sufficiently supported the child or young person; work with parents/carers was sufficient in less than half. The joint work of home and host YOTs was judged sufficient in only 47%.

3.17. In the main, in the cases in the sample, initial assessments and plans were reviewed at appropriate intervals although over one-third of both were of insufficient quality. A similar proportion of the reviews of vulnerability and the risk of harm to others were also judged to be insufficient. The latter was particularly concerning given the circumstances of these children and young people.

3.18. The attention paid to the risk of harm to others was of concern; changes in relevant risk factors were only anticipated in about half of the cases in the sample and appropriate action taken in the same amount. Reviews of risk of harm were not always carried out following a significant change. Of the seven cases involving Multi-Agency Public Protection Arrangements, the procedures were not used effectively in two. Case managers had given sufficient attention to the safety of victims or potential victims in only 60% of cases. Given that other children and young people were living alongside them and were potentially at risk, this was of particular concern.

3.19. Frequent placement moves hampered the work to address offending behaviour and to manage the risk that children and young people posed to others. This was particularly worrying where there was a risk to others within the residential system and to staff.

Joseph, a 16 year old, was taken into care due to physical abuse and had five placements since 2010. He was assessed as posing a high risk of harm to other people; however, the host YOT was not advised when he had to be moved because of allegations of rape by another resident of the children's home. He had been moved into a shared house with floating support and the home YOT was not aware that he was there. The host YOT found out by accident and as a result plans to manage the risk that he posed to other children and young people in the house were not in place.

3.20. Perhaps because of the poor assessment of the emotional impact, we saw little concession made to the type of relationship building needed with children and young people who are away from home and have been moved about. For example, we sometimes saw enforcement procedures carried out precipitously, with little thought to how the process of engaging a child or young person in care and so far from home might differ from those used with one living with their family and within their own localities.

Good practice examples: working with individual need

Jenny, 13, found the number of people involved in her life confusing. Within a short period she had lived in three different children's homes in her home area before being moved away. She had between four and six contacts a week with different professionals over and above her education. The **Blackpool** (host) YOT worker helped Jenny understand 'who was doing what' and made her a timetable showing where her appointments were and with whom.

Cissie, a 14 year old girl, was angry and her behaviour towards residential staff was hostile and had resulted in several convictions for assaults within the children's home. She was placed in **Shropshire, Telford & Wrekin** where some excellent work was carried out with her. One session involved looking at her anger and what it meant. She was able to identify that sometimes it masked other emotions such as worry, anxiety and hurt. Together she and the case manager used a number of scenarios to identify the top five situations in the children's home where she was likely to lose her temper and devised ways to avoid it happening.

Gary had offended and caused damage within a previous residential placement. The **Blackpool** (host) YOT worker worked hard to engage him and carried out some good offending behaviour work around the offence within the children's home. Gary then completed reparation where he refurbished an old table. As he was unable to give it to his original placement, he presented it to his current residential placement.

Work to reduce criminalisation in children's homes

3.21. Referral orders constituted 30% of the cases inspected which would indicate that those children and young people had probably not previously offended. Given that restorative justice was attempted on only four occasions it seems likely that prosecution could have been avoided in at least some of those cases. Whilst there is no national official data to prove or disprove it, sentencers and staff working in the

field told us that, in their view, children and young people continued to be prosecuted for offences within children's homes which would not have attracted police attention in a home environment.

3.22. Restorative justice is an approach that focuses on the needs of the victims and the community in which the offence occurred, instead of merely punishing the offender. It emphasises repairing the harm caused by offending behaviour. Victims are encouraged to take part in the process, while those who have committed offences are encouraged to take responsibility for their actions, to repair the harm they have done — for example by apologising, returning stolen money or carrying out some work in the community.

3.23. It is recognised that this approach can be particularly relevant and useful in children's homes to avoid the unnecessary involvement of the formal criminal justice system. If a restorative justice approach is used by residential staff as an integral part of helping and managing children and young people, it can prevent bad behaviour becoming a criminal matter and avoid the involvement of the police. CPS guidance acknowledges that the police are more likely to be called to a children's home than to a domestic setting and specifically mentions restorative justice as a possible alternative to court proceedings.

3.24. As this approach has gained momentum over recent years, YOTs in some areas have engaged in successful partnership work with children's homes to avoid criminalising children and young people. Unfortunately, in the areas we visited, it was generally impractical for YOTs to offer advice or training in restorative justice techniques to residential staff due to the number of children's homes in their area. In the 19 cases in the sample where restorative justice might have been attempted, it had been carried out in only four.

Good practice example: work to reduce criminalisation

Halton and Warrington YOT had linked a case manager to particular residential units to improve joint working and the YOT court manager attended an accommodation providers' forum in Halton which most of the private providers also attended. Their reparation worker had also offered restorative justice training to one of the units in the area which had been positively received.

YOT Liaison with children's homes

3.25. Host YOT workers reported a variety of interactions with residential staff. Some YOTs had made significant efforts to establish working relationships with key workers and attempts had also been made in some areas to foster good general working relationships with placement providers in order to improve, amongst other things, the compliance with courts orders. However, in areas with large numbers of children's homes this was not always practical. The shift pattern of key workers was also a factor. Notwithstanding this, we saw some instances of interventions carried out within children's homes and key workers transporting children and young people to meetings at the YOT.

The YOT role in multi-agency working

3.26. The added value that YOT staff bring to work with children and young people who are looked after is their specialist knowledge and expertise in the assessment of, and work with, offending behaviour and public protection. They also have particular skills in making relationships and working closely with adolescents and teenagers. YOT work is carried out through regular contact with those under supervision. For some, it may be as much as three times per week, a level of contact that other agencies do not have. Aside from the residential key workers, it was very often the YOT worker with whom the child or young person had the most contact. Significantly the children and young people we interviewed were overwhelmingly positive about their relationships with their YOT workers.

Quotes from children and young people about the YOTs

"The work I did with the YOT made me realise it was really stupid, what I had done. It made me realise there were other ways I could have dealt with the situation".

"I look forward to coming to the YOT".

"I get on well with my YOT worker. She hasn't given up on me".

3.27. It was disappointing therefore to note the lack of understanding and appreciation of the role of YOT workers by some external agencies and the failure to seek their input about placements or, worse, to ignore of their views. It was also not unusual for YOT workers to be left off the invitation list to reviews by IROs and for the minutes of the meetings not to be sent to them. We saw more than one occasion where key workers in children's homes not only failed to remind children and young people of their YOT appointments but actually took them out on an activity when they should have been engaging with the YOT. In one case the YOT worker went to the children's home to meet with the young person and walked into a review to which she had not been invited.

3.28. Many social workers and IROs did not recognise the significance of the child or young person's offending behaviour and the work to reduce it, regarding it as peripheral to the child or young person's life and to the planning that they were doing. Yet the impact on a child or young person of their offending behaviour and on their future life chances can be immense. Additionally, few professionals took account of public protection issues and did not give sufficient consideration to potential victims, which could be other children and young people in residential placements.

3.29. The contribution of YOT case managers to multi-agency meetings was judged to be effective in only 18 of the inspected cases. For example, we sometimes found little input into the meeting other than the provision of information. YOT staff were not always as assertive in multi-agency settings as they needed to be. It was not only in the children's social care services arena but also in Multi-Agency Public Protection Arrangements meetings, where they were sometimes disregarded or sidelined.

3.30. The use of jargon and assessment tools specific to YOTs such as Asset scores or a RoSH did not help other professionals in those settings to understand the significance of the information which they brought. YOT staff needed to understand the audience, use language that was immediately understood and tailor their input into multi-

agency meetings to increase their influence. Too often we saw that YOTs were present but that their contribution had had little impact in the decision-making.

Larry, a 17 year old, was on a full care order and was assessed by the YOT as posing a high risk of harm to people. He had a history of threats and making weapons. He was subject to Multi-Agency Public Protection Arrangements Level 2 oversight. The YOT involved took steps to manage the risk of harm well. The risk assessments prepared by YOT workers documented a history of watching houses when he was placed in a residential setting and then targeting vulnerable victims for burglary. Unfortunately this did not appear to have been taken into account in determining the best placement and Larry went on to break into nearby properties.

Kelvin had a history of concerning behaviour including tying another child to a tree, fire setting and sexually harmful behaviour. According to YOT records he had previously been in at least two different out of area placements. The placement broke down due to a sexual relationship with a 14 year old girl in the same children's home. Neither home nor host YOT was advised of this by the social worker. The new placement was in the house of a member of Kelvin's extended family; there were young children in the household and we found no evidence of any suitability checks or assessment by children's social care services.

Good practice example: multi-agency working

Bournemouth and Poole YOS worked with IROs to help them improve the safeguarding of the children and young people they were working with. On a regular basis, IROs examined the safeguarding aspects of YOT cases to ensure that it was given the appropriate priority. This contributed to improved safeguarding work by the YOT. The additional confidence gained by YOS practitioners improved their effectiveness in multi-agency meetings helping them to ensure that other agencies delivered relevant services to these children and young people. In addition, the IRO was able to share areas of practice identified by YOS workers with colleagues across children's social care services.

Conclusion

3.31. The specific circumstances of the lives and experiences of these children and young people were not always fully recognised and taken into account by YOTs (home and host) and the work with them was affected by this. Overall, however, host YOTs were working hard to support and supervise children and young people placed in their area and were successful in establishing relationships with them. This was often against a backdrop of a strain on their resources and was too frequently compromised by inadequate or delayed information from home YOTs and other agencies. This was of particular concern in the management of the risk that was posed to others and which was compounded by a failure, at times, of other agencies to fully understand and appreciate the role of YOT workers.

4. Working together

Summary

This section describes the joint work of the various agencies involved with the children and young people and its impact on them.

Key findings

- Local authority responsibilities for children and young people placed out of area are complex and there is little use of data to inform resource planning.
- Local authorities did not always use children's homes within their own locality that were used by other local authorities because of concerns about their suitability.
- The decision about which children and young people are safe and suitable to live together is made by the providers. Placing local authorities generally do not know who the other residents are.
- There are a large number of professionals with whom individual children and young person have relationships and the number increases with each change of placement.
- Agencies often fail to work effectively together, concentrating on their own procedures and failing to work with the child or young person in a coordinated way.
- Many assessments do not lead to any meaningful intervention or change in the child or young person's life and many plans are not integrated or contradict each other.
- YOT workers reported that they had little information available to them about the content and quality of work in therapeutic units.
- The role of IRO is not always carried out effectively. There is little challenge about suitability of placement and little coordination of planning.

Strategic management

4.1. At the local authority level, responsibilities for this group are complicated. Effectively there are two distinct groups of children and young people for whom senior managers have responsibilities: their own, which they have placed outside, and those from other authorities who are placed in their area. The local authority has different duties towards each of these two groups. Corporate parent duties towards children and young people placed in another area remain with the home local authority. In all but one of the areas we visited, senior managers were aware of the children and young people whom they had placed outside their area and familiar with their individual circumstances.

4.2. The host local authority has a duty to safeguard *all* children within its geographical boundaries; this duty is administered through the Local Children's Safeguarding Board. When placing a child outside their home area the placing authority should notify the receiving authority. In practice, this is inconsistent. Therefore it is possible

that a local authority, which has a duty to safeguard, may not know that a child or young person is in their area. Local Children's Safeguarding Boards varied significantly in the way they addressed the issue. Some were actively pursuing information about those children resident in their area and considered what services might be extended to them whilst others took a more reactive approach focused on their safeguarding responsibility.

4.3. We found that for those local authorities with a number of children's homes in their areas it was a significant resource issue as well as a challenge to safeguard a population of children for whom they did not have accurate data. The registration and inspection of children's homes is carried out by Ofsted (in England) and the Care and Social Services Inspectorate Wales (in Wales) and information is provided by these organisations to the relevant local authority on a regular basis. However, a children's home has no legal responsibility to advise the local authority of its presence and the local authority has no responsibility for monitoring the children's home. In practice, the host local authority very often has little interaction with individual children and young people although they may be well know to the local criminal justice agencies – courts, police and YOTs.

Good practice example: provision of services

Halton local authority had taken the stance that the children and young people in their area were 'theirs' and that all should receive the same quality of services. For example, they provided a summer school for children and young people in care to help with transition to the next year in education and this was open to those children and young people from outside the area. They have made significant efforts to 'map' the children's units in their area to enable them to keep track of children and young people from outside.

Good practice example: understanding out of area placements

In Cambridgeshire, thought was being given to how to involve lead members more in the lives of the children and young people for whom they are responsible. One suggestion was that they could visit those in out of authority placements in order to get a better picture of their experience.

4.4. It was noteworthy that we saw a number of cases where the local authority had taken a decision that they would not use providers within their own geographical boundaries despite other local authorities regularly using them. In these circumstances, we would have expected local authorities to make checks with each other about the reasons for these decisions to ensure the safety of the children and young people they were placing there. We found none however. Therefore, it was unclear to us how one local authority could be sure that the placement was safe and of good quality when another had taken a different view.

4.5. In the areas we visited we found that there was little data collected that could be used to inform policy and practice or to determine the resources required locally to properly deliver services. Some attempts had been made address this deficit, for example some YOTs had calculated the percentage of these cases on their workload (it ranged from 10% to, at times, as much as 20%). However local authorities were not generally aware of information about the children placed in their area. Where they did have data, it was about those that they themselves had placed elsewhere.

4.6. In local authorities with clusters of children's homes, no one was able to tell us exactly what the impact was on local services such as education, substance misuse, mental health or criminal justice although it was often felt to be significant. Some agencies had explored the possibility of attempting to charge for these services without success. Managers in more than one YOT told us that the resource needed to supervise children and young people from outside the area had meant that they were less able to supervise those who were from the local area.

Good practice example: use of data

Essex YOT had significantly improved their knowledge of children and young people who are looked after through thorough interrogation of data already held by the YOT and children's services. They felt that this had enabled them to influence the placement decisions about Essex children and young people which had had an impact on the sustainability of the placement and reduced offending within the residential setting. They also believed that it had improved the interface with the IRO, ensuring that youth justice issues were properly considered in care plans.

Accommodating and managing diverse need

4.7. We saw little evidence of any corporate parent asking about the details of other residents before placing children and young people in a particular home. This was left to the agency which was being paid to provide the placement. They, in turn, could only make any decision based on the information they were given, which was sometimes incomplete. We were told by residential staff that problems often arose with the quality and quantity of information in cases placed at weekends as emergency placements. This was particularly worrying given that by their nature those children and young people are likely to be distressed and very unsettled. On occasion, residential agencies moved children and young people from one children's home to another without prior discussion with the local authority; hence any initial enquiries made about other residents became invalid.

Tanya had come into care when she was 11, following sexual and physical abuse. The host YOT supervising her was also supervising a young man, Ian, who had several allegations of sexually harmful behaviour against him. The YOT asked the care provider, who had several homes in the area, not to place them together and this was agreed. Two months later a third young person, Lisa, moved into the area and was supervised by the YOT. It was at this point, when Lisa alleged that she had been sexually assaulted by Ian that the YOT found out that Tanya had in fact been moved to the same children's home as the young man.

Therapeutic and specialist placements

4.8. A small number of children and young people in the sample were placed in units which specialised in working with children and young people who exhibited sexually harmful behaviour. We saw no evidence in the cases we inspected that social workers, IROs or commissioners had checked the content or quality of the therapeutic input. YOT staff also reported that they had very little information on which to make an assessment of the quality of the regime provided in such units and its suitability for an individual child or young person. Some of this very small group of children and young people may pose a high or very high risk to other people and if they reoffend

the consequences for victims could be grave. Some specialist placements were accredited by the Community of Communities, a voluntary body run by the Royal College of Psychiatrists. It was unclear to us how accreditation was achieved or how relevant it was in some cases, given that sexually harmful behaviour is not normally classified as a psychiatric illness.

Angus, 14, was placed in a unit specialising in sexually harmful behaviour. The unit had eight other boys at the time although it could hold 12. Along with two 16 year old boys, he absconded from the unit and later claimed that he had been sexually assaulted by them. A police investigation took place. The boys all remained at the unit.

Joint working

4.9. This group of children and young people often have a substantial number of workers involved in their lives. Their 'looked after' status requires them to have a social worker and an IRO. Their involvement in the criminal justice system can also require them to have a supervising YOT officer if made subject to an order and their out-of-area placement means that they will have another YOT worker in the area in which they live. They will also have key workers in each residential placement as well as education professionals and those from other agencies such as mental health or substance misuse. With each move, the number of relationships they are required to start and finish increases.

4.10. We found effective joint working between YOTs and children's social care services in only one-quarter of cases, and with education and mental health services in just under a half. In our discussions with different agencies, when we asked about joint work most agreed about the need to share information; however, there was much less understanding of what working together actually meant in practice. In the cases in the inspection sample we saw little joint assessment and no joint planning between any agencies.

4.11. Agencies did not always use the same terminology and language. The use of the word *risk* is an example of this. It was often used by agencies but meant different things to each. Within children's social care services, for example, the term generally refers to the risk of harm to children and young people, whereas within the arena of youth offending, it generally means the risk that they pose to other people. It is also used by some agencies to describe the risk of self-harm or suicide. Such lack of precision leads to misunderstandings and the potential for duplication or, more worryingly, omission. There was misunderstanding and suspicion between some agencies. Other agencies did not feel that their assessments and plans were always taken into account.

4.12. For many children or young people we found some work that was good or excellent and we met individual professionals, at all levels, who were extremely committed and working very hard to improve lives. However, the lack of joint working meant that the *whole* intervention that the child or young person received was not as successful, as it could be. For example, we saw a YOT Child and Adolescent Mental Health Services (CAMHS) worker carrying out some valuable, individual work with a young person, but failing to contribute to the wider assessment or planning about the risk of harm they posed to other people or addressing their vulnerability.

4.13. Working across local authority boundaries exacerbated this problem. Where one agency had made efforts to improve services, it was often compromised by the work of another. There were exceptions and it was noticeable in the Halton & Warrington YOT that efforts had been made to improve joint working with other agencies, both home and host, and we saw examples where this had benefited the child or young person.

4.14. In the main, however, what we saw was agencies working in isolation, with periodic meetings to exchange information and update staff from each agency involved with the child or young person. We saw little evidence of a 'team around the child' approach. Individual workers concentrated on the requirements of their own agencies and held that to be the important task. Where there was a lead agency in a specific decision-making environment, for example in Multi-Agency Public Protection Arrangements meetings or children's social care services review meetings, the lead agency view normally held sway.

Joint assessment and planning

4.15. We found a large number of assessments and plans completed by different organisations. Assessments did not always result in any intervention or change of approach. We saw some cases where there were conflicting assessments and delays in decisions pending the next assessment. In particular, we saw a number of psychiatric and psychological assessments that contradicted each other.

Alex was taken into care aged five years old. His father and stepfather were in and out of prison. He had witnessed domestic violence and possibly sexual activity. He had 13 foster placements, the last breaking down in 2009. He then went to a children's home followed by more foster carers and then a respite placement for a number of months. He exhibited some very worrying, sexualised behaviour.

He was assessed by a specialist social worker, within the same local authority, who refused to share the assessment with the YOT who was working with him.

4.16. In the YOT assessments we saw, and in those on YOT case files from other agencies, we found little mention of the stages of child development and no consideration of the context of 'normal' teenage behaviour. We saw very little mention of attachment and the consequences of the losses that these children and young people faced. We found a lot of reactive work and plans for the next, short-term move. We saw no long-term plans and no aspiration for anything other than the provision of basic services.

4.17. There were few instances of agencies planning and implementing shared ways of working. Unfortunately, what that meant in practice was that the overall benefit to the individual child or young person was diluted or even lost.

4.18. It was particularly disappointing to see the lack of planning for those leaving custody, given that here was an opportunity to make plans well in advance. The date of release is known early on and the child or young person's needs are well known. However, we saw more than one case where decisions were not made until the last minute.

Winston, 16, had had 31 different placements since coming into care aged three years old. He had a history of violent behaviour and possessing weapons. His 16 year old girlfriend, also looked after, had given birth to his daughter and was made the subject of child protection procedures, whilst he was in custody. Agencies were concerned that he posed a risk to the child and to the public.

His accommodation was not identified until the day before his release.

4.19. When making placements children's social services rarely took account of YOT assessments and recommendations, resulting in offending that might have been avoided. This also meant that staff and other children and young people were potentially at risk of harm. We found a number of cases where young people who had been assessed by the YOT as posing a risk of harm to others went on to assault other residents of the children's home.

4.20. We also found that children's social care services frequently failed to advise YOTs of placement moves. Conversely, where children's social care services had alerted the home YOT to a change of placement, home YOTs also sometimes failed to pass on information promptly to the host YOT. Either way, this meant that children and young people were without supervision under their court orders for periods of time, giving the message that compliance with court orders was unimportant. Similarly, where placement staff with little or no knowledge of the child or young person accompanied them to court, this gave a powerful message to the child or young person about their own lack of importance as well as impacting on the quality and speed of judicial decisions. In addition we found that placement staff and other agencies often failed to work together to deal with challenging behaviour in the children's home and prevent it becoming criminalised.

Transition between agencies

4.21. The legislation requires local authorities to ensure that a pathway plan for a Looked After Child is in place before the child or young person's sixteenth birthday. This plan is pivotal and should detail needs and aspirations in the areas of education, training and employment, accommodation, personal support and contingency planning amongst others. Children and young people are entitled to a range of clearly defined support and this can last until they are 24 years old in come cases. In practice, in the cases we looked at, support often waned significantly when they reached 16 years. We saw little evidence of long-term strategy or of professionals working together with the child or young person to prepare and plan for the move out of care and into independent living.

4.22. All of the cases in the sample were still being managed by YOTs although some of the young people were approaching their eighteenth birthdays. The general practice of YOTs is not to transfer cases to the local probation trust in the middle of supervision when young people reach 18 unless there is a long period of supervision still to do or adult services are considered more appropriate. We found little evidence that YOT staff had been involved in the planning for transition to more independent living and we judged that joint planning and work with children's social care services was insufficient in nearly three-quarters of the cases.

Kelvin was taken into care as a young child and adopted. This broke down when he alleged physical abuse and he was placed in residential schools. At 17 years old, he was placed in bed and breakfast accommodation and then moved in with his half brother who was on probation for a violent offence. None of the professionals involved contacted the probation officer to assess the risk he posed. Kelvin was violently assaulted by his half brother.

Impact on children and young people

4.23. The lack of good quality joint working had many consequences, not least that a child or young person gets asked the same questions over and over again and may be asked to discuss things that are painful with many different professionals who are strangers. They are expected to continually make new relationships and then say goodbye.

4.24. None of the assessments, by any of the agencies that we saw, seemed to fully appreciate and take into account the immense impact of being in care and of being continually moved on.

4.25. As important, is the quality of decision-making which is compromised by agencies not taking into account the whole picture, but seeing the child or young person's circumstances through the prism of their own agency's responsibilities. On too many occasions, in the cases we inspected, children's social care services did not appear to appreciate the impact of offending on the child or young person and on other children and young people; YOTs did not seem to fully recognise the need to influence the wider work with the child or young person and CAMHS and substance misuse services did not see it as part of their role to share in risk assessment.

4.26. In many of the cases that we inspected crucial information not passed on, promises to children and young people not kept, requests not carried out, and decisions continually delayed.

4.27. Very often, we found children and young people drifting towards their sixteenth birthday, having had poor and patchy education, no work on their emotional well-being, no work on family relationships and little or no planning for successful transition to independence. We saw no instances where IROs had held agencies to account for poor inter-agency working.

Sam, a 17 year old, had been taken into care at a young age. It was suspected he had been sexually abused. He himself had allegations of rape of 12 young girls against him and violence against care staff.

In the approach to his eighteenth birthday, he had been placed in an isolated, rural placement with two-to-one staffing which reflected the degree of supervision that the local authority felt was necessary to keep him and others safe. Sam's residential placement was due to finish within a matter of months at the same time as his supervision by the YOT expired. He had no contact with his family. Despite four recent, separate assessments, there were no plans for future accommodation. This potentially left him with little support and no management of the risk he continued to pose to other people.

Conclusion

4.28. The circumstances of the lives of these children and young people and the number of different agencies involved with them makes effective joint working essential. It was particularly disappointing therefore to see how compartmentalised it was. We saw much hard work directed by individual staff to the objectives and processes of their own agencies with the child or young person at the centre of any number of assessments and plans without evidence that anything had either changed or improved. Moreover we found a too ready acceptance of the need to merely manage these children and young people through the system, a lack of aspiration for their future and an absence of longer-term planning. IROs, who could have played a robust role in ensuring that the work of all agencies was properly coordinated for the benefit of the child or young person, did not see this as their role.

Appendix 1: Legislation and Guidance

There is a considerable amount of legislation and guidance underpinning the work with this group of children and young people. Here we have briefly outlined that which we consider to be the most relevant to this inspection.

National Policy

At a national level, the Department for Education is responsible for children and young people who are looked after. The Ministry of Justice, through the Youth Justice Board, is responsible for services to children and young people who have offended. The Children's Minister convenes a cross-government meeting of Ministers, including the Justice Minister, to encourage more joined-up policy making.

Ofsted is the Office for Standards in Education, Children's Services and Skills. Ofsted inspects and regulates services which care for children and young people, and those providing education and skills for learners of all ages. Ofsted reports directly to Parliament and is independent and impartial. They assess children's services in local areas, and inspect services for children and young people who are looked after, safeguarding and child protection.

In Wales, Care and Social Services Inspectorate Wales inspects and reviews local authority social services, and regulates and inspects care settings and agencies including children's homes and residential special schools. Care and Social Services Inspectorate Wales carries out its functions on behalf of Welsh Ministers. It is an independent inspectorate within a department of the Welsh Government.

Youth offending work

Youth Offending Teams were set up under the Crime and Disorder Act 1998 with the purpose of reducing the risk of children and young people offending and reoffending. Youth Offending Teams supervise children and young people on court ordered remands and community orders and work with those who have received custodial sentences.

The Youth Justice Board provides direction to Youth Offending Teams and monitors performance. *National Standards* 2009[9] together with the *Scaled Approach*[10] provide guidance for assessment and planning and suggest levels of contact and intervention. The Protocol for Case Responsibility (England Only) *Practice advice for youth offending teams* (undated) details processes for the management of cases across local authority boundaries.

Youth Offending Teams sit within a variety of directorates across the countries, mainly, but not exclusively, those of children's or community safety. The supervision of court orders **may** remain the responsibility of the home Youth Offending Team but be delivered by the host Youth Offending Team, may be transferred or the home Youth Offending Team may decide to retain delivery.

Crown Prosecution Service legal guidance on youth offenders[7] described the decision to prosecute offending behaviour within a children's home as a major decision to be taken by a youth specialist. It acknowledged that residents of children's homes are at high risk of reoffending as a result of the type of placement in which they live. The reasons for the charging/diversion decision should be clearly recorded and show the factors that have been considered by a youth specialist to determine how the public interest is satisfied.

Children and young people who are looked after

The Department for Education provided *Statutory Guidance on the Roles and Responsibilities of the Director of Children's Services and the Lead Member for Children's Services 2012*.[11] The functions for which they are responsible are set out in s.18(2) Children Act 2004. This includes (but is not limited to) responsibility for children and young people receiving education or children's social care services in their area and all children and young people looked after by the local authority or in custody (regardless of where they are placed).

The Children Act 1989 placed a general duty on local authorities to secure, so far as reasonably practicable, an outcome for children and young people who are looked after with regard to their accommodation. The outcome envisaged was that the accommodation would be within the authority's area and that it would meet their individual needs.

The term 'corporate parent' was introduced in 1998 and launched the concept of collective responsibility within local authorities for good parenting of children and young people in public care. It directed that the local authority must have the same interest in the progress and attainments of children and young people who are looked after as a reasonable parent would have **for their own children**. It envisaged senior officers together with the lead member for children's services as being accountable for these responsibilities.

Statutory guidance on securing sufficient accommodation for looked after children[12] was issued by the Department for Children, Schools and Families in 2010. This guidance was introduced "to improve outcomes for looked after children". With effect from April 2011 "local authorities must be in a position to secure, where reasonably practicable, sufficient accommodation for Looked After Children in their local authority area.

New Care Planning, Placement and Case Review (England) Regulations[13] came into force in April 2011. They were designed to improve the quality and consistency of care planning, placement and case review for children and young people who are looked after. They also aimed to improve the care and support provided to care leavers. Amongst other things they outlined the role of the Independent Reviewing Officer. This was covered in Wales by the Placement of Children (Wales) Regulations 2007[14].

The Independent Reviewing Officer

The appointment of an Independent Reviewing Officer is a legal requirement under Section 118 of the Adoption and Children Act 2002. IROs make an important contribution to the goal of significantly improving outcomes for Looked After Children. Their primary focus is to quality assure the care planning process for each child, and to ensure that their current wishes and feelings are given full consideration.

The IRO Handbook 2011[15] provides guidance to IROs about how they should discharge their distinct responsibilities to children and young people who are looked after. The aim of the handbook was to achieve improved outcomes for children and to provide the support and services that each one required to enable them to reach their potential.

The Children (Leaving Care) Act 2000, the Care Leavers (England) Regulations 2010[16] and the Children (Leaving Care (Wales)) Regulations 2001[17] make provision for the advice, assistance and support local authorities provide to children and young people aged 16 and over who are leaving care. The regulations include provision for local authorities' assessment of the needs of these young people, about the preparation of the local authorities' 'pathway

plan' to provide them with advice, assistance and support, and prescribe the functions of the personal advisers appointed for children and young people.

Providers of children's homes in England are required to comply with children's homes regulations, registered, regulated and monitored by Ofsted and in Wales with Care and Social Services Inspectorate Wales.

Education

The responsibility for the arrangement of education rests with the placing authority however once the child or young person resides within an area, the host local authority has a duty towards the child or young person to provide education.

Joint working

Working together to safeguard children[18] set out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004.

The *team around the child* was a model of service delivery. It involved a multi-disciplinary team of practitioners established on a case-by-case basis to support a child, young person or family. Team around the child supported particular elements of good professional practice in joined-up working, information sharing and early intervention. The idea was to place the child or young person and family at the centre of the process, to have joined-up assessment and a lead professional to coordinate work.

Appendix 2: Glossary

CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
Children Act 1989 – Section 47	Section 47 of the Children Act 1989 places a duty on local authorities to make enquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these enquiries indicate the need, to undertake a full investigation into the child's circumstances
CPS	Crown Prosecution Service
DfE	Department for Education
Estyn	HM Inspectorate for Education and Training in Wales
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Home YOT	Refers to the YOT where the child or young person normally resides or, in the case of a Looked After Child, the YOT of the placing local authority
Host YOT	Refers to the YOT which provides criminal justice services to a child or young person who does not normally reside within that YOT's geographical area
IRO	Independent Reviewing Officer
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
Safeguarding	Overseen by the Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children and young people in that locality
YJB	Youth Justice Board for England and Wales
YOT/YOS/YJS	Youth Offending Team/Youth Offending Service/Youth Justice Service

Appendix 3: Role of the inspectorates and code of practice

HMI Probation

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

http://www.justice.gov.uk/about/hmi-probation

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

HM Chief Inspector of Probation
6th Floor, Trafford House
Chester Road, Stretford
Manchester M32 0RS

Estyn

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

http://www.estyn.gov.uk/

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

HM Chief Inspector of Education and Training in Wales
Anchor Court, Keen Road
Cardiff CF24 5JW

Ofsted

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

http://www.ofsted.gov.uk/

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

HM Chief Inspector of Standards in Education, Children's Services and Skills
Aviation House, 125 Kingsway
London, WC2B 6SE

Appendix 4: References

1. (May 2011) *The care of looked after children in custody: A short thematic review*, HMI Prisons, London

2. (May 2011) *The hidden truth about homelessness*, Crisis, London

3. (January 2011) *From Care to Independence: Improving employment outcomes for care leavers* Reed in Partnership Ltd, London

4. (October 2009) Lamont, E., et al. *provision of mental health services for care leavers: transition to adult service*s, National Foundation for Educational Research, Slough

5. (January 2012) Professor Gillian Schofield et al *Research study - Looked after children and offending: Reducing risk and promoting resilience*, TACT, London

6. (March 2012) CHILDREN'S HOMES IN ENGLAND DATA PACK, Department for Education, Cheshire

7. Youth Offenders: Legal Guidance, The Crown Prosecution Service, London, http://www.cps.gov.uk/legal/v_to_z/youth_offenders/

8. (2010) *National Protocol for Case Responsibility (England Only): Practice advice for youth offending teams*, Youth Justice Board for England and Wales, London

9. (2010) *National Standards for Youth Justice Services*, Youth Justice Board for England and Wales, London

10. (2010) *Youth Justice: the Scaled Approach*, Youth Justice Board for England and Wales, London

11. (April 2012) *STATUTORY GUIDANCE ON THE ROLES AND RESPONSIBILITIES OF THE DIRECTOR OF CHILDREN'S SERVICES AND THE LEAD MEMBER FOR CHILDREN'S SERVICES 2012*, Department for Education, Cheshire

12. (2010) *Sufficiency: Statutory guidance on securing sufficient accommodation for looked after children*, Department for Children, Schools and Families, Nottingham

13. The Care Planning, Placement and Case Review (England) Regulations 2010

14. The Placement of Children (Wales) Regulations 2007

15. (March 2011) *IRO Handbook: Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children*, The National Association of Independent Reviewing Officers, Department for Children, Schools and Families, Nottingham

16. The Care Leavers (England) Regulations 2010

17. The Children (Leaving Care) (Wales) Regulations 2001

18. (March 2010) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Department for Children, Schools and Families, Nottingham

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

ISBN: 978-1-84099-584-8