

# Accommodation of Homeless 16 and 17 Year Old Children Working With Youth Offending Teams

A joint inspection by HM Inspectorate of Probation

**September 2016**

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# Foreword

In 2009, the House of Lords gave a landmark judgment clarifying the responsibilities of children's social care services for the provision of accommodation and support to homeless 16 and 17 year olds. With the impetus of the Southwark judgment<sup>1</sup>, local authorities reviewed their procedures and (alongside others) produced new protocols, guidance and pathways. The prospects for homeless 16 and 17 year olds were improved as it paved the way for better access to accommodation and support services because of the judgment and the commitments that flowed from it.

Six years on, this inspection revealed a mixed picture on the ground. Most distressingly, one in three 16 and 17 years olds in our inspection were housed in accommodation we considered unsuitable or unsafe. We were particularly concerned about the risks those sharing hostel or bed and breakfast accommodation with adult strangers were exposed to.

No one local authority suggested to us that these shortcomings were because of a lack of funding. They appeared to stem more immediately from poor or incomplete assessment, a lack of joined-up working and recognition of children's wider needs, and a tendency to place children as though they were adults. Our inspection found that the range of suitable accommodation provision was limited and this resulted in some children being placed in accommodation that did not meet their needs.

The children whose cases were reviewed had all suffered some form of trauma in their lives. Most had been previously known to children's social care services and some were subject to care orders<sup>2</sup>. They often exhibited difficult behaviour. All of those whom inspectors saw were not yet capable of successful independence and still needed some form of parenting and support. Again, we found a mixed picture on the ground. A minority received excellent support, whereas too many had been given a roof over their heads with little other than a few hours a week support from visiting professionals.

An important factor in the successful transition of children to independent adulthood was the continued provision of support when they reached 18 years old. This was not available to all children, the deciding factor being whether they had become Looked After under the *Children Act 1989*, giving them rights as care leavers to support beyond the age of 18 years.

It is not known how many 16 and 17 year olds find themselves alone and relying on their local authority for accommodation to avoid homelessness. The data and information collected locally and collated nationally<sup>3</sup> is not sufficiently comprehensive or joined-up. In our inspection of six local authorities we saw no evidence of Local Safeguarding Children Boards exercising any scrutiny of the local situation. What is more, in areas where there were shortfalls, senior managers seemed tolerant and accepting of the state of affairs.

Refreshingly, we found examples of excellent practice, and we set out specific examples in this report.

In summary, two in three children were in suitable accommodation; one in three was not. The wider support they received was of variable quality – sometimes excellent, in other cases woefully inadequate. These differences are hard to comprehend, given the clear intentions of the Southwark judgment.

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1 R (on the application of G) v London Borough of Southwark [2009] UKHL 26. The full transcript can be downloaded from [tinyurl.com/gvsouthwark](http://tinyurl.com/gvsouthwark)

2 A care order is given by a court. It allows a local authority to take a child into care under the *Children Act 1989*.

3 Throughout the report, national refers to England and Wales only.

The recommendations in this report are intended to make the accommodation for homeless 16 and 17 year olds safer and the support provided to them more effective, so as to increase their prospects of successful, adult independence.



**Dame Glenys Stacey**

*HM Chief Inspector of Probation*



**Imelda Richardson**

*HM Chief Inspector of Care and Social Services  
Inspectorate Wales*

*September 2016*

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## Background and inspection methodology

In 2009, in what is now known as the Southwark judgment, the House of Lords ruled that the primary responsibility for the accommodation of homeless 16 and 17 year olds rests with children's social care services under the *Children Act 1989*. Prior to that, many local authorities discharged their duties through housing departments under homelessness legislation.

This Southwark judgment clarified the law. Consequently, children's social care services had to meet accommodation costs that they had not recognised previously as their responsibility. In response to the judgment, the Department for Communities and Local Government funded action by English local authorities to roll out homelessness pathways, and issued joint guidance with the Department for Education. The focus was on the prevention of homelessness and the appropriate provision of accommodation and support to homeless 16 and 17 year olds.

In similar fashion, the Welsh Government issued guidance and undertook training and support work with all Welsh local authorities. Additionally, more recently, it commissioned further work on the development of accommodation and support pathways for homeless 16 and 17 year olds. The impact of this was not evident at the time of our inspection due to fieldwork predating implementation.

Six years have elapsed since the Southwark judgment, but our findings in our mainstream inspection work suggested that the provision of suitable and safe accommodation to homeless 16 and 17 year olds known to Youth Offending Teams (YOTs) remains problematic in some cases; hence this thematic inspection.

Working with Ofsted and Care and Social Services Inspectorate Wales, our inspection focused on the experience of children in accessing and maintaining accommodation as they were moving towards adulthood. We inspected 49 cases across 6 local authorities. These were children who were known to Youth Offending Teams and unable to live with their parents. We excluded cases where children had been taken into care for their own protection. At the time of the inspection, of the 49 cases:

- 41 were boys; 8 were girls
- 25 were aged 16 years; 24 were aged 17 years
- 38 were classified as White British; 3 were classified as White Other; 4 were classified as Black British; 1 was classified as Mixed ethnicity; 2 were classified as Other ethnic group and 1 was not recorded
- 32 had been Looked After at some point in their life
- 15 had spent some time in custody; 6 were still awaiting release.

Where possible and appropriate, we talked to them and their parents/carers about where they were living, how they were coping and what support they needed. We also interviewed:

- staff and managers within the Youth Offending Teams
- staff and managers from children's social care services
- accommodation providers – including staff, managers and commissioners
- Chairs of the YOT management boards
- Chairs of Local Safeguarding Children Boards
- representatives from national organisations with oversight of this work.

Where there were concerns about the safety of individual children<sup>4</sup>, cases were referred to the local authority for follow up action.

Throughout this report all names referred to in practice examples have been amended to protect the individual's identity.

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<sup>4</sup> The names of the children in the practice examples have been changed.

## Summary of findings

The homeless 16 and 17 year olds in this inspection were not a homogeneous group, but all had experienced disturbing life events. Their relationships were damaged, their behaviours were often problematic and their futures were uncertain. Their needs could not be met simply by the provision of a roof over their head.

### Assessment

All local authorities had documented assessment pathways to assess children's needs, but the process and quality of assessment differed considerably. Not all local authorities routinely considered the need to provide accommodation under section 20 of the *Children Act 1989*. In some areas, all the children we saw had become Looked After by the local authority; in others, none had. Looked After status is significant, given the longer term support that comes with it (see Legislation and guidance).

Failure to consider, as part of the assessment process, the need to accommodate homeless 16 and 17 year olds under section 20 of the *Children Act 1989* was likely to have a detrimental impact on their longer term well-being. We were told by some local authorities that, as children could not become Looked After under section 20 without their permission, it had not been possible to do so. Other areas, however, had been successful in persuading children of the benefits of becoming Looked After.

There were too many assessments that were resource led, fitting children into what was available. While this worked for some children, those with the most complex needs had to exhaust the usual placements before they were considered for more bespoke packages. This meant that some children suffered numerous and unnecessary placement breakdowns.

Too often, the services offered were solutions more geared to adults, and did not properly meet these children's needs. Little account was taken of the fact that they were still children and that most of them still needed some form of parenting, rather than simply accommodation and remote support services.

### Suitability of accommodation

We found one in three of the children whose cases we inspected to be in unsuitable or unsafe accommodation. Some placements put children at risk from unknown and/or dangerous adults and some provided perfunctory and inadequate support. Of those children in good quality supported accommodation, a detailed look at their background often revealed a history of previous unsuitable placements.

In the better performing areas there was varied provision, and what we saw was suitable. This ranged from small units with live-in support available all day every day, to supported lodgings, where children were able to live with host families. Suitable emergency accommodation was also available.

In other areas, children were routinely placed in hostel or bed and breakfast accommodation where they were living alongside unknown, and in some cases dangerous adults.

### Impact

As assessments did not generally take into account the emotional and other needs of the children, the level of support provided alongside accommodation varied substantially. That is likely to lead to differing outcomes, for example in relation to prospects of employment, or levels of loneliness and isolation.

Unsuitable or unsafe accommodation brings its own risks: notably a risk of harm from other people in the accommodation and to other people in the accommodation. Conversely, where children had been placed in suitable, supported accommodation, it was evident that they were able to take advantage of the support provided and progress towards independence.

Planning for the future (both short and long term) was weak in too many cases. Contingency planning was almost entirely absent. In those cases where a placement was breaking down and there was no contingency plan we found overuse of unsuitable, sometimes unsafe, emergency accommodation such as bed and breakfast and all-age hostels.

### **Joint working with YOTs**

Providing accommodation is not within the remit of YOTs. Nevertheless, they worked alongside children's social care services and providers and made an extremely positive contribution overall. They understood how significant being without suitable accommodation was and worked hard, and in partnership with others, to support children. With few exceptions, they actively communicated and shared information with others involved. They often had the most regular contact and positive relationship with the child and, where they were used appropriately, their contribution was particularly valuable.

Unfortunately, not all social workers used YOT case managers' skills and knowledge to full effect. They were not always consulted or advised when changes were being planned, and this was sometimes to the detriment of the child.

### **Local and national oversight**

There was little evidence of local or national oversight, effective monitoring of accommodation placements or adherence to the national guidance<sup>5</sup> on suitability of accommodation.

Both local and national scrutiny was hampered by a lack of information. Useful data was generally not collected at a local level with the exception of that required by national government departments. In England, two central departments each collect data, but it was not sufficiently complete or joined-up. The Department for Communities and Local Government received some data from local authority housing departments on children placed in bed and breakfast accommodation by them. It was felt by some professionals that the collection of this data had helped to reduce the numbers of children placed by housing authorities in bed and breakfast accommodation. It did not, however, tell the whole story. The number of children placed by children's social care services in bed and breakfast accommodation was not reported and the Department for Education only collected data on homeless 16 and 17 year olds who were care leavers. The collection of data in Wales had only recently commenced.

The use of unsuitable or unsafe accommodation was tolerated at a local level. We found no evidence that this issue had been considered by local YOT management boards or Local Safeguarding Children Boards. Not all Chairs of Local Safeguarding Children Boards were aware of the Southwark judgment and its requirements, and there was no evidence that scrutiny of the accommodation of homeless 16 and 17 year olds had taken place, even where there was unsafe accommodation being routinely used.

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<sup>5</sup> Guidance and regulations (of the *Children Act 1989*) Volume 3: planning transition to adulthood for care leavers (England)

# Recommendations

## **Directors of Children’s Social Care Services in England and Directors of Social Services in Wales should make sure that:**

- the accommodation provided for homeless 16 and 17 year olds is safe and appropriate to their individual and assessed needs
- assessment pathways for homeless 16 and 17 year olds are kept under review and where appropriate upgraded in line with established best practice
- the vulnerability of homeless 16 and 17 year olds is fully recognised by staff and that services are tailored to their individual needs, including their emotional well-being
- when determining which services to provide to homeless 16 and 17 year olds, consideration is given in the assessment process to whether it is in children’s best interests to be accommodated under section 20 of the *Children Act 1989* and the longer term benefits are explained to them
- children’s social care services routinely include YOT case managers in joint assessment and planning where relevant, and work with them to provide and maintain good quality accommodation for children
- a local needs analysis is undertaken and used to inform the provision and delivery of good quality, suitable and safe accommodation and support services for homeless 16 and 17 year olds
- homeless 16 and 17 year olds are not placed in accommodation alongside adults who may pose a risk of harm to them
- the assessment of the accommodation and support needs of homeless 16 and 17 year old children in custody commences on sentence
- homeless 16 and 17 year olds leaving custody have suitable, safe and settled accommodation at the point of release and that they are aware of where they will be living well in advance of release
- develop systems to monitor and reduce the number of failed accommodation placements experienced by 16 and 17 year old homeless children.

## **Chairs of Youth Offending Team Management Boards should:**

- scrutinise Youth Offending Team data on the accommodation status of 16 and 17 year olds on their caseload to make sure that every child is in safe and appropriate accommodation
- hold partners to account for the placement of children in safe and good quality accommodation

## **The Department for Education and the Department for Communities and Local Government in England should work together to:**

- develop monitoring systems that enable government to comprehensively understand the number of 16 and 17 year olds placed in bed and breakfast or other unsuitable accommodation and set clear expectations of local government to improve.

## **The Departments for Education and Public Services, and for Health and Social Services in the Welsh Government should work together to:**

- develop monitoring systems that enable government to comprehensively track the number of 16 and 17 year olds placed in bed and breakfast or other unsuitable accommodation and set clear expectations of local government to improve.

# Legislation and guidance

# 1

# 1. Legislation and guidance

## Summary

This chapter outlines the key legislation and guidance on the provision of accommodation and support for homeless 16 and 17 year olds.

## Key facts

- The primary responsibility for accommodating and supporting homeless 16 and 17 year olds rests with local authority children's social care services.
- The suitability of accommodation is the subject of national guidance. Bed and breakfast accommodation is not deemed to be suitable for those in priority need (which includes 16 and 17 year olds) except in cases of emergency, where it should be risk assessed and its use strictly time limited.
- Unless homeless 16 and 17 year olds are accommodated under section 20 of the *Children Act 1989*, they have no legal right to continued support from children's social care services when they reach 18 years old.

The duties and responsibilities to homeless 16 and 17 year olds are set out in English and Welsh children's and housing legislation and supported by guidance<sup>6</sup>. Longer term safeguards and support are significantly better for those children who become accommodated under section 20 of the *Children Act 1989*.

## Key legislation

**The *Children Act 1989***<sup>7</sup> requires local authorities to safeguard and promote the welfare of children. These duties are discharged through local authority children's social care services, and other agencies have a duty to cooperate with the authority. This includes making sure that a child is provided with accommodation which meets their needs, including the provision of accommodation under Section 20 (when they become Looked After).

Where local authorities are Looking After older children making the transition to adulthood, there is a requirement for the authority to have arrangements in place to support effective planning for leaving care. The child remains entitled to care leaving support and there is a continuing focus on working with the child and other agencies to achieve the best possible outcomes.

**The leaving care provision in the *Children Act 1989*** and related regulations set out statutory requirements for children preparing to leave care. Following assessment, each child must be provided with a pathway plan which sets out the services needed to successfully support a child's transition to adulthood. This plan must be kept under regular review.

**NB: Leaving care legislation applies only to those who have been in the care of the local authority for specific periods of time, whether subject to a care order under section 31 or accommodated under section 20 of the *Children Act 1989*.**

<sup>6</sup> See appendix 1

<sup>7</sup> The *Children Act 1989* was amended by the *Children (Leaving Care) Act 2000* to make provision in relation to leaving care.

***The Social Services and Well-Being (Wales) Act 2014*** provides the duty to assess the needs of a child for care and support where it appears to a local authority that a child may need care and support in addition to, or instead of, that which is provided by the child's family. The authority must assess whether the child does need care and support of that kind, and if so, what those needs are.

***The Housing (Wales) Act 2014*** re-establishes the priority need for accommodation of 16 and 17 year olds in Wales but also places a new duty on local housing authorities to both prevent and relieve homelessness under Sections 66 and 73 respectively.

**The Southwark judgment 2009<sup>8</sup>** restated, clarified and confirmed that the primary responsibility for accommodating homeless 16 and 17 year olds rests with local authority children's social care services. Baroness Hale, in giving the lead judgment, stated: 'The clear intention of the legislation is that these children need more than a roof over their heads and that local children's services authorities cannot avoid their responsibilities towards this challenging age group by passing them over to the local housing authorities'.

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<sup>8</sup> See appendix 1

**The assessment  
process:  
establishing  
entitlement to  
accommodation  
and support  
services**

**2**

## 2. The assessment process: establishing entitlement to accommodation and support services

### Summary

This chapter describes briefly the background of the cases we inspected, the differing processes within the local authorities for providing accommodation and support services, and the impact of those on children.

### Key findings

- All of the children whose cases we inspected had experienced difficult life events. There were none who simply needed accommodation.
- All local authorities had assessment pathways in place. Some were excellent while others were inadequate. As a consequence, children with similar needs experienced very different levels of service and support depending on the quality of the pathway of the local authority.
- Local authorities differed in their approach to determining whether a child should be provided with accommodation under section 20 of the *Children Act 1989*. The failure to consider, as part of the assessment process, the need to accommodate homeless 16 and 17 year olds under section 20 of the *Children Act 1989* was likely to have a detrimental impact on their longer term well-being.

### About these children

These children were not merely without accommodation. All of those whose cases we inspected had experienced significant difficulties in their lives, some more extreme than others. Two in three had been Looked After at some point, with some on care orders (where children's social care services had statutory responsibility as corporate parents). Common themes were neglect, parental loss, physical and sexual abuse and family relationship breakdown. Not surprisingly, these children often exhibited difficult behaviour. Fifteen had spent time in some form of youth custody.

It was not always obvious that these were confused, sad, lonely or frightened children. Their life experiences did not lead them to trust adults. They did not find it easy to articulate their needs. Some with the most complex needs were disruptive. Their behaviour presented children's social care services, accommodation providers and other agencies with real challenges in helping them.

As they moved toward adulthood, their immaturity and vulnerability was not always apparent. Where assessments did not always recognise this, they were too often offered adult solutions - namely accommodation and limited support - rather than services more geared to the needs of children.

### **Practice example: Impact of inadequate assessment of a child's needs**

Sixteen year old Sam was forced to leave the family home by his mother, after his stepfather had left blaming Sam for his departure. At a young age, Sam had seen his birth father try to strangle his mother. He had also witnessed ongoing domestic violence by his stepfather over a period of years. It was known that Sam had anaemia, was not taking his medication and went long periods without food.

Sam spent his first night of homelessness in a garden and then stayed with a friend for a short period before being placed at a housing project for 16–25 year olds by the housing department. His mother moved out of the area. We found no recognition of the impact of any of these events on Sam's emotional state. Children's social care services had no involvement and offered no support or services although a referral had been made.

### **Accommodation pathways, protocols and guidance**

In 2012, the Department for Local Communities and Government (DCLG) announced its intention to fund St. Basils, a youth homelessness charity, to promote the use of a youth accommodation pathway and innovative approaches to youth homelessness, working with local authorities and leading voluntary sector providers over 2012-2013<sup>9</sup>. The Positive Pathway<sup>10</sup> provides a helpful framework for local authorities and their partners to use locally to provide a planned approach to homelessness prevention and housing for young people.

The inspection found that, in line with their legal obligations, local authorities had designed pathways and established protocols and guidance for the delivery of accommodation and support services to 16 and 17 year olds. These varied considerably, and had noticeably different and significant impacts on children. While all complied with legal requirements, not all reflected the unequivocal intentions of legislation and the Southwark judgment. We saw, however, some examples of good practice.

The arrangements generally involved joint work between children's social care services and housing authorities. Some areas had set up processes for the two services to work together to find the most suitable solutions.

Some children, however, were placed by children's social care services and others by housing authorities, and in practice, there were varying levels of service and provision across England and Wales. In one local authority, we saw a system that did not properly assess children's needs. Assessments were carried out by housing workers who had had some basic training to assess other needs. This had had a significant, detrimental impact on the type of accommodation and support services that were offered to homeless children.

These differing arrangements had an impact on the provision and service to children. They also meant that central government's understanding of performance was patchy and incomplete, as the number of children placed in bed and breakfast accommodation by housing departments has to be reported, but not those placed by children's social care services.

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<sup>9</sup> St. Basil's, *Developing Positive Pathways to Adulthood: Supporting young people on their journey to economic independence and success through housing advice, options and homelessness prevention 2012 (updated 2015)* developed by, St. Basils, a youth homelessness charity, with the advice of local authorities, social landlords, homelessness agencies and young people and provides guidance on developing effective homelessness pathways.

<sup>10</sup> See appendix 3

### **Good practice examples: Services which made accessing accommodation easier for homeless children**

In Enfield we saw the impact of a pathway that reflected fully the Southwark judgment. We found well organised and integrated end-to-end services from mediation and support to prevent unnecessary homelessness, through to provision of accommodation and support where necessary. A single point of entry made sure that all services were engaged as early as possible. Tasks were allocated to professionals depending on relationships rather than agency boundaries. There was good use of a high-risk panel, a Young Person's Housing Support Steering group and the placement team who worked well together. The YOT was fully integrated into homelessness services.

In Nottinghamshire, we were told about a pathway<sup>11</sup> which was in its early stages but was viewed by external experts as being a model of good practice. There was a variety of provision enabling children to progress through to independence, while meeting their needs at every stage. This started with emergency accommodation where necessary, progressing to a core service providing self-contained bedsits with 24 hour staff cover and communal areas. There was a follow-on cluster service which comprised self-contained or shared accommodation with visiting support.

Hartlepool used a First Contact and Support Hub which was within the same building as the YOT and had close links. The hub used a Multi-Agency Safeguarding model which included the police, the domestic violence service and an education officer. A Child and Adolescent Mental Health Service therapist was due to join the team. As a result, children were assessed without delay.

In the Vale of Glamorgan we saw a one-stop shop which was the first point of contact for those aged under 18 years old experiencing housing need. The service was delivered by children's services in collaboration with the main local provider, Llamau. The environment was child friendly and welcoming. Staff were knowledgeable and sympathetic. Mediation services were explored initially followed by a full needs and housing assessment where necessary. There was an understanding of the potential benefits of the child being Looked After.

### **Good practice example: Swift access to suitable accommodation**

In Enfield, 16 year old Jamie presented as homeless when his parents refused to have him home after he had been missing for a weekend. His behaviour had been deteriorating and there had been previous support provided to attempt to keep him with the family. He was accommodated under section 20 of the *Children Act 1989* on the day of presentation in a safe and suitable placement, close to home with 24 hour staff cover. At the point of inspection he had been living there for 12 months.

### **Practice example: Failure to properly assess a child's needs**

Jonathan, aged 16 years old, had lived with his grandmother since he was 3 years old. When his elder brother was released from prison and moved in with them things quickly deteriorated. His brother damaged the property to the extent that it became uninhabitable. Within days Jonathan had been placed on his own in a one bedroom house. Support was minimal, involving weekly visits from housing support workers and contact with the YOT.

When we interviewed Jonathan, he cried. He told us: *"It was a choice of a house or a hostel. I wasn't ready to move out. I would have liked to be fostered. I could have focused on my college. It's lonely and boring. There's nothing to do except watch telly. I am worried about getting into debt. It wasn't my fault I had to move out. Now everyone else is living happily and I am stuck on my own"*.

<sup>11</sup> See appendix 2

## Looked After status

During assessment, the decision as to whether a child should become Looked After under section 20 of the *Children Act 1989* was made.

The impact of Looked After status is significant for children as they move towards independence. Looked After Children become care leavers, with legal rights and protection, and **are eligible for support until they are 21 years old (or 25 in some circumstances)**. Those who are offered accommodation and support without this status may receive similar services while they are 16 and 17 years old. The impact at 18 years old, however, was described to us by one professional as “*dropping off the edge of a cliff*” in terms of provision and support.

Areas differed substantially in their approach to determining whether a child should be provided with accommodation under section 20. In one area, all of the children in our sample had Looked After status. In another, none had.

Looked After status did not correlate directly with the standards of accommodation and support provided to 16 and 17 year olds. We found services were good in one area where all had been made Looked After and also in another where none had been made Looked After. In a third area, where none of the children had been provided with accommodation under section 20, we saw some placements which were dangerous and had put children at risk of harm. We found, however, a difference in the quality of accommodation provided to children. The proportion of those either accommodated under section 20 of the *Children Act 1989* or subject to care orders who were in good enough quality accommodation was considerably higher than those who did not have that status.

With the exception of Enfield and Norfolk, local authorities told us that most children, when asked if they wanted to become Looked After, were vehemently opposed to this course of action. As their consent is required, this stopped local authorities taking this course. We questioned how proactively the benefits of Looked After status could have been explained and found that children’s views and wishes were not routinely captured in assessments.

We were also told that the status was kept under review so that children could become Looked After if necessary. We saw no evidence of this in the cases we inspected.

### Practice example: Loss of support at 18 years old

Scott was described by his YOT case manager as an “*emotionally naive and fragile young man*”. He was removed from his parents at a young age as a result of domestic violence and placed with his aunt. When this broke down at 17 years old, he lived in a garden shed for 3 months. When he came to the attention of the YOT, children’s social care services placed him into emergency accommodation where he did not cope well. He was a vulnerable young man open to bullying and assaults by others. He was subsequently placed in a hostel. It became apparent that he was giving his food away to a local family and begging. His social worker met with the family to deter them from abusing him in this way, however, this was difficult to manage at arms length and he remained vulnerable.

Scott told us that he missed his family and that when he first became homeless he told children’s social care services that he would be interested in being fostered. They are said to have responded that it wasn’t worth it at his age.

Scott was due to be 18 years old at the end of 2015 and children’s social care services were intending to close his case as he did not have Looked After status. YOT supervision was due to finish around the same time leaving him with no support. It was unclear at the time of the inspection whether he would be eligible for adult mental health support.

More than one local authority expressed concern to us that the impending changes to housing benefit entitlement will affect 18 year olds disproportionately, and make it difficult for them to access any settled accommodation, either in the private or social housing sectors. The proposed changes include the loss of automatic entitlement to housing benefit for young adults and a local rate cap, and we were told that this will make it almost impossible for a young person who is not working to afford to live in anything other than a shared property. Professionals involved believe it will be yet more challenging to provide 'move on' accommodation for those with complex needs or who are vulnerable, or pose a risk of harm.

### **Progression and individual needs**

In some cases the age of the child was driving planning, rather than their individual needs. This was particularly apparent for those who would not have care leaver status. The transition to independence is different for each child, but systems did not always take this into account. Most children faced an accelerated transition for which they were not ready. In some cases, agencies had unrealistic expectations of the child's ability to manage or move on.

Most professionals understood that children might not manage to maintain their first foray into independence, or indeed their second, third or fourth, and that safeguards and services needed to take this into account. Children might need to move back to a more structured, caring environment such as foster care. We were told by some local authorities that this option was available to children in their area although we saw no evidence of this within our case sample.

Housing professionals told us that there was a risk in some places that children (other than those exempt because of their Looked after status) could end up with an 'intentionally homeless' decision<sup>12</sup> because they had been evicted for rent arrears or antisocial behaviour or were deemed to have 'abandoned' their accommodation. This would be a significant decision, as they would not then fall within the main statutory homelessness duty under homelessness legislation, but a lesser duty of a restricted period of time for temporary housing (28 days in England and up to 56 days in Wales).

### **Practice example: Failure to properly assess maturity or understand a child's needs**

Aged 15 years old, Michael returned from abroad, where his mother and father lived, to live with his cousin. This was not successful and he moved around various friends and family for 10 months until he presented as homeless aged 16 years and 8 days. He was placed in emergency accommodation, in a high rise block. We visited this accommodation and judged it to be entirely unsuitable for a 16 year old, and unsafe. He had been referred by the housing department to children's social care services but they had not taken any action to assess his needs. Two weeks later, he presented again, this time directly to children's social care services, saying that he felt unsafe where he was living. Again, children's social care services failed to accept responsibility for him, so Michael was moved by housing services to another flat.

It was recorded that this was in an area where crime and drug use were prevalent. It was also recorded that he was timid, lacking in confidence and could be easily influenced and that it would be in his best interests to be relocated to supported accommodation, more suitable for a child of his age. This was not pursued.

<sup>12</sup> A decision made by housing authorities which restricts the legal duty to provide accommodation to homeless people, including 16 and 17 year olds.

## Conclusion

The effect of the Southwark judgment had been to improve access to accommodation and support for homeless 16 and 17 year olds. In the local authorities that had embraced the judgment, children were more likely to get the support that they needed to progress to independent adulthood. Effective and easy to use pathways facilitated swift access and took into account both current and longer term needs of the child.

Too often though, there was a failure to recognise children's emotional and developmental needs as distinct from their practical requirements, and this led to accommodation and support services that did not properly meet their needs as older children. This contributed in some cases to placement breakdown.

Crucially, there was a failure to make sure in all cases that children fully understood and appreciated the longer term benefits of becoming Looked After under the *Children Act 1989*. In our view there were serious failures in the assessment process to fully reflect the needs of 16 and 17 year old children who presented as homeless. This potentially impacted on children being able to access effective services which met their particular needs and to be accorded the right status under the *Children Act 1989*.

# Suitability of accommodation

3

## 3. Suitability of accommodation

### Summary

This chapter outlines the variety of accommodation provided that we saw.

### Key findings

- The accommodation we saw varied considerably. Thirty-three of the forty-nine children were in accommodation judged to be suitable. One in three were in unsuitable or unsafe accommodation.
- Most accommodation was not regulated or inspected by the children's social care services inspectorates, Ofsted or Care and Social Services Inspectorate Wales (CSSIW).
- Some accommodation provided good, in-house support all day every day. Others left children alone with a few hours of visiting support per week.
- In some places, the use of bed and breakfast and hostel accommodation was routine, leaving children living with unknown, and sometimes dangerous adults.

### Types of accommodation

The type of accommodation varied across, and within, the areas we visited. A small number of children had been placed in residential children's homes, some out of area. Most were in accommodation that was not regulated or inspected by Ofsted or CSSIW (the inspectorates responsible for children's homes). There were fewer safeguards for children placed there.

We found some good and varied provision across all the local authorities, although some had a higher proportion which we considered good enough. We were pleased to see that, in some authorities, children were placed in smaller units with 24 hour support, seven days a week. We also found a small number of units that took only 16 and 17 year olds (with some 18 year olds who had stayed on after their birthdays).

Specific emergency accommodation was also available in most areas though this varied considerably in quality. Supported lodgings were available in some areas, and being developed in others, although in one place they were only available to Looked After Children. Tenancies guaranteed by the local authority, were available to under 18s in some areas.

### Good practice example: Provision of suitable and safe accommodation with appropriate support levels

In Wales, there was a good range of accommodation through the provider Llamau. Those units we were able to see were of good quality and child friendly. Other professionals in children's services and YOTs were positive about their services. The supported lodgings scheme allowed children to stay after their 18<sup>th</sup> birthday and had links with a local college; four children had obtained a National Vocational Qualification in health and social care through this route.

In Hartlepool, we saw a small, local residential unit of six self-contained units that had been commissioned by the local authority and had been operational for approximately four years. The unit accepted 16-25 year olds although the average age of the occupants, at the time of the inspection, was 17 years; there was a 50/50 gender split. Five of the six occupants were in education, training or employment. We were told that local children had been consulted about their needs in the commissioning process.

## **Unsuitable or unsafe accommodation**

All of the local authorities told us that they used bed and breakfast in emergency situations only, and for very short periods. We saw cases, however, where children had been there for weeks, and in one case it had become a permanent placement. In one area, every child whose case we inspected had spent some time in bed and breakfast accommodation.

Several local authorities placed children in hostels that took adults, often with criminal records. The hostels usually had upper age limits of 25 years old, although some had no upper limit. The background of the other adults placed there was not always known. None of the hostels had waking night staff. Communal areas offered little or no supervision to vulnerable children.

One of the hostels we saw, taking 16 to 25 year olds, both male and female, was approximately two miles up a narrow, unlit country road with no pavements or public transport. The manager conceded it was potentially dangerous and had suggested the use of high visibility jackets. We judged it to be unsafe for children.

### **Practice example: The consequences of placing children in unsafe accommodation with adults**

Karen had been made the subject of a full care order in November 2012 after years of neglect and domestic violence within her home. Aged 16 years old, she had had to leave a children's residential home and was placed at a mixed hostel (above) where she met a 22 year old man who became her partner. It later transpired that he had a criminal record and a history of violence towards partners which was not known to either the YOT or children's social care services. When he was evicted due to his behaviour, Karen left with him. For a substantial period the pair lived in a tent.

At the time of the inspection Karen, now 17 years old, had been placed by children's social care services in bed and breakfast accommodation with him. Agencies appeared to have little active involvement in supporting her, other than making sure that staff visited to monitor her welfare. Her aunt had reported seeing bruising to her face and there had been police call outs for domestic violence.

## **Emergency accommodation**

We found a tolerance of the 'emergency' use of bed and breakfast at all levels, even though it was conceded that these establishments are unregulated, and it was impossible to monitor the other residents and ensure the safety of children placed there. We were concerned to find a case of a Looked After Child who had been resident in a bed and breakfast establishment when a violent crime had taken place on the premises.

One local authority used a high-rise block of flats as emergency accommodation. The block housed up to 96 people of all ages and backgrounds who were not all known to those placing children there.

## **Particular vulnerability**

The inspection found that girls were particularly vulnerable in settings where they were living alongside male adults. Of the eight girls whose cases we inspected, seven had safeguarding needs and in five of those cases, the accommodation provided had not helped to keep them safe.

## **Conclusion**

Provision varied considerably. Some local authorities had evidently made substantial efforts to provide good and varied accommodation for homeless 16 and 17 year olds. We were concerned, however, to see the use of what we considered unsuitable or unsafe accommodation in some cases.

Some of the provision we observed was unsafe for children. It did not meet the statutory duty to promote their welfare and safety. This was particularly so in the case of emergency accommodation. We found no systems in place anywhere to make sure that other residents in bed and breakfast accommodation were not considered a danger to children. As such, and in line with government guidance we judged the use of such accommodation to be unacceptable.

# Impact

# 4

## 4. Impact

### Summary

This chapter outlines how the assessment and planning of services impacts upon the experiences of homeless children.

### Key findings

- Assessment did not generally take into account the emotional needs of children. The levels of support provided to children once placed were noticeably different, with some much more likely to lead to good outcomes than others.
- Assessments were largely resource led, with children being fitted into what was available. For those with the most complex needs, this contributed to more placement breakdowns.
- Contingency planning was almost entirely absent, leading to too many emergency placements. Some could have been avoided with better and more timely planning.
- Planning for children's accommodation on release from custody was variable, and sometimes last minute.

### Support

For those children dealing with the inevitable marginalisation that being housed outside of family structures brings, support was crucial. Suitable accommodation should include or be accompanied by appropriate support in order to achieve the best outcomes for these children.

Depending on the type of accommodation, support structures were very different. For some children living in supported accommodation, support was available to them 24 hours a day, seven days a week. Additionally, in some places, we saw communal activities and regular sharing of meals which went some way to helping to meet the child's emotional needs.

Some providers clearly understood that the children with whom they were working with needed emotional as well as practical support. One described them as being "*in my care*" and said that "*they needed parenting*".

In other cases, children were living alone and receiving visits from a number of different professional staff. Loneliness was a real issue for these children. As one said: "*I was used to living in a family. There were always people around. Now there is no one*".

### Assessment and placement

In most of the areas we visited, the placement of children and the support delivered was decided on the basis of a formal assessment of their accommodation and support needs, and involved children's social care services. Some of the assessments that we saw were very detailed, however, they too often started with the end provision in mind. In other words, the needs identified did not always determine the outcome; the child had to fit into whatever provision was available.

In particular, we judged that the assessment of their emotional needs **as children** was superficial at best and non-existent at worst. Some assessments tended to focus on housing need only, as opposed to the needs of the child. As a result, the accommodation and the level of support they received did not meet their needs. There was little evidence that children had been able to make an informed contribution to the assessment.

The provision was resource led. In some areas, and cases, we considered that the accommodation was good enough to meet children's immediate, *practical* needs. In others, it was not. In those local authorities using unsuitable and/or unsafe accommodation, children's needs were clearly not met. Assessments, where they were carried out at all, were perfunctory and merely complied with a procedure.

In the local authorities that had good and varied provision, most children received a service that was good enough to meet their accommodation needs. The issue for those authorities was the placement of children with especially complex needs. Too often their needs had not been met and the accommodation had, therefore, broken down. They had, therefore, been moved through a number of placements, before they were considered for something more individually tailored.

Good quality assessments of individual needs should have identified these children so that they did not have to go through the damage of failed placements. In a number of cases, YOT workers and social workers told us that the child had a history that would indicate difficulties in maintaining particular types of accommodation and they had known that the next placement would fail. We saw a small number of cases where we felt that the use of secure accommodation to protect the child should have been considered.

### **Contingency planning**

The weakest area of practice was contingency planning. We saw little evidence of this in any of the local authorities we inspected.

This had a real impact on children. Too often, they ended up in emergency placements (often bed and breakfast accommodation) with inherent risks to their safety. Some breakdowns were entirely predictable and even expected. In discussions with YOT and social workers, we were told a number of times that behaviour was deteriorating, that warnings had been given and that they thought it was inevitable that the child would be evicted. When we asked what the plan was in the event that this happened, we were told that they would then 'go back to placement panel' or they would 'consider a return to residential care'. We saw too many cases where children were placed in unsafe accommodation while processes took place which could have been set in train much earlier. Some of these 'emergencies' could, and should, have been averted.

### **Practice example: The consequence of not having Looked After status and poor contingency planning**

Jack was subject to a Child Protection plan when his stepfather, who misused alcohol, hit him with a wine bottle. Jack also had difficulties with alcohol and had visited hospital 3 times in the previous 12 months due to heavy use. The family had been known to children's social care services for several years. In March 2015, when Jack was 17 years old, his mother would no longer allow him to live at home and he was accommodated, initially in bed and breakfast and then in hostel accommodation. He was working with the YOT under a court order and his case manager had made unsuccessful representations to children's social care services that he should be made Looked After.

As Jack approached 18 years old, it was apparent to all involved that his placement was breaking down but there was no contingency planning. At the time of the inspection, Jack's court order had expired, he had been evicted from his accommodation and his social worker closed his case on his 18<sup>th</sup> birthday.

On the same day, he had to present, as an adult, to the local authority homeless team.

### **Practice example: The difference made by contingency planning**

In one case we found that a lack of contingency planning contributed to a crisis and an unnecessary period in prison for a child who was clearly demonstrating severe distress.

In 2014, when Bernard was 16 years old, his mother was hospitalised with a severe stroke. In September of that year, he became involved with the YOT and in December, he appeared in court following violence to his father. As a result of a restraining order he was not allowed to go home.

Bernard was placed in bed and breakfast accommodation by children's social care services and, over the next four weeks, he was in 3 different bed and breakfast hotels and a hostel for 16-25 year olds. As a result of a minor breach of his bail conditions, he ended up in custody for three days. When he was released, he was placed back at the hostel. Bernard went missing several times and was admitted to hospital on numerous occasions through drug misuse, once suffering a cardiac arrest.

In June 2015 things changed.

A new social worker was allocated to Bernard. He was reassessed and a strategy meeting was held followed by some excellent planning which improved outcomes significantly.

As Bernard was missing at this point, contingency plans were put in place for when he was found. A warrant was issued and when he appeared in court the social worker and YOT worker were able to put detailed information and plans before the District Judge.

Bernard was placed in a secure unit on a welfare basis for 72 hours to stabilise him. He was then moved into a therapeutic placement where he settled well and responded to the work and the environment. In the meantime, work was carried out with his father to plan for an eventual return home. Detailed plans were put in place for him to return home including support for his father through other agencies. The restraining order was revoked and in August 2015, he went home. In November (at the time of the inspection) he was settled at home with his father, was engaging well with his social worker, had found himself a part-time job and had recently started to see his mother.

### **Resettlement**

Some of the children whose cases we inspected had spent time in custody resulting in added barriers to finding suitable accommodation. YOTs have specific responsibilities for planning and supporting children in custody and for supervising them on release, however it remains the duty of children's social care services to find suitable accommodation.

For some, their accommodation on release was not certain and plans needed to be put in place. This was not always carried out well enough and children did not always know where they would be living until far too late. This caused anxiety and made planning for other support or education, training or employment difficult or even impossible.

### **Practice example: The consequence of poor resettlement practice**

Lonnie, a 17 year old Looked After Child in the South of England, did not find out until three days prior to his release where he was going to live. This caused him considerable anxiety and his preparation for release was compromised. The accommodation turned out to be an out of authority placement in the North of England and he went missing almost immediately.

On a more positive note, we saw some good resettlement practice where efforts were made to make sure that children knew where they would be living within a reasonable time frame, and in some cases, were able to return to a previous placement.

### **Good practice examples: Supportive and proactive resettlement practice**

In Hartlepool we saw resettlement planning begin at the start of Brian's 18 month detention and training order (DTO). He had no family contact of any sort. Prior to custody, he had been living and settled in supported accommodation which he described as "*like a family*".

Although Brian would be 18 years old before he was released, he was a care leaver (as he had been Looked After) and was therefore entitled to support. A number of professionals, were intending to visit him regularly while he was in custody, over and above the legal requirements in acknowledgement of his lack of family. The plan was for him to return to his previous placement.

Tom had been placed at a residential school in August 2014 and was studying for his GCSEs when he was sentenced to a 12 month DTO. The local authority (Norfolk) paid to keep the placement open for Tom to return to, which he did. He took his GCSEs while in custody.

Rashad, 17 years old, has a troubled family background, a history of running away from care and placement break down due to his disruptive behaviour. Both his social worker and YOT case manager in Enfield had worked hard to find him a placement in an area away from his gang associations but within reach of his mother and siblings. While he was in custody, a care home was identified and visits arranged so that staff could meet him before his release. This was greatly appreciated by Rashad who felt that, as a result, they had a better understanding of his needs. He was released to the accommodation and settled well. When he reoffended, the placement was held for him for 69 days so that he would be able to return upon his release from custody.

In Blaenau Gwent & Caerphilly, we found an example of good provision and support to 18 year old Melvin who was entitled to leaving care services.

Melvin had been on a full care order since 2011 and had had numerous placements. In October 2014, when he was 17 years old, he was sentenced to eight months custody. During that period both his YOT case manager and social worker had worked closely together to plan for his accommodation and support on release. He had known in December where he would be living on release the following February. His emotional needs had been assessed and taken into account; he was released to a singleton placement with 24 hour support. The choice of staff member had also been given considerable thought and he was more settled in the placement than he had been anywhere else.

At the time of our inspection, some regions in England have set up resettlement consortia with the help of Youth Justice Board grants to improve resettlement work for children in custody and on release. We were told by Nottinghamshire, part of the East Midlands Consortium, that they have used some of their grant to hold accommodation for a short period prior to release.

### **Outcomes**

Where children had been placed in suitable, supported accommodation, it was evident that they were able to take advantage of the support provided and progress towards independence.

Of the children whose cases we inspected however, only two in three were in what we judged to be suitable accommodation and even then, they had often experienced unsuitable or in the worst cases, unsafe accommodation on the way. Almost one in three were not settled in their accommodation and one in four did not have their safeguarding needs met.

At the point of inspection, nearly two out of three of the children whose cases we examined were, or had been, accommodated under section 20 of the *Children Act 1989* or subject to a care order. There was a marked difference in the quality of the accommodation that they received. Three-quarters of them were judged to be in suitable accommodation, and settled, while this was the case in only half of those without that status. Further, four out of five who were either accommodated under section 20 or subject to care orders were judged to have had their safeguarding needs met, whereas the proportion for those without that status was just over half.

In half of the cases we inspected, we judged that the accommodation contributed to helping children stop offending through the provision of a more stable and supportive environment where they were expected to abide by rules and where there were expectations about their behaviour. In those cases, the potential harm that they posed to others was also managed.

In the other half of cases, there was no evidence that the accommodation helped children to stop offending or contributed to good risk management. It was not possible to determine the impact on children of living alongside adults who were also offending but we judged that it could not be positive.

The immediate risks of unsuitable and/or unsafe accommodation were apparent in many of the cases we reviewed, notably a risk of harm *from* other people in the accommodation and *to* other people in the accommodation. The consequences were also apparent: placement breakdowns, failure to progress to employment or training, and isolation and loneliness.

It was not possible to measure the wider, long term impact of the lack of suitable and safe accommodation for children but it was difficult to see how these experiences could contribute to positive outcomes or to reducing reoffending.

## **Conclusion**

The successful placement and the provision of effective support were reliant on a good quality assessment of all the child's needs, not just the practical housing need. Too often we saw inadequate or resource-led assessments and in the worst cases, no assessment at all.

This posed fewer problems in less complex cases and/or in areas where the provision was good, with in-house support. In some cases, however, it left children inadequately housed, unsupported or even unsafe.

The decision on what accommodation to provide and the accompanying support required staff to recognise each child's individual and emotional needs, and to understand that most continued to need parenting of some sort.

The absence of contingency planning was a real weakness. Its absence made it inevitable that more children ended up in emergency accommodation with all the insecurity and potential danger that that entailed.

For the small number of children in custody who did not have settled accommodation for release, the assessment required by the Southwark judgment needed to commence early in their sentence, to inform accommodation planning and prevent homelessness on release.

Overall, there was a marked difference in the suitability of the accommodation provided to those children who were either accommodated under section 20 the *Children Act 1989* or subject to care orders and to the meeting of their safeguarding needs.

# YOT partnership work

# 5

## 5. YOT partnership work

### Summary

This chapter outlines the contribution of YOTs to the support of homeless 16 and 17 year olds.

### Key findings

- Overall, YOT case managers, accommodation workers and other YOT staff were making a valuable contribution to supporting children.
- Where YOTs were involved, case managers were often the professionals who had the most regular contact with children and were, therefore, in a position to make a valuable contribution to the work to support accommodation.
- Children's social care services did not always value the knowledge and skills that YOTs brought and did not fully involve them as partners, to the detriment of positive outcomes being achieved by children.

The primary role of YOTs is to reduce reoffending. They also have a responsibility to protect the public from the risk of harm that a child may pose. Where children are homeless or in unsuitable/unsafe accommodation, case managers need to work closely with children's social care services and other agencies as they are often the professional that has the most contact.

We found good, and some excellent, partnership work by YOT case managers with other professionals dealing with accommodation issues, often providing the support that other agencies did not. In the most effective YOTs, case managers understood that stable and supportive accommodation was a prerequisite for any offending behaviour interventions to be successful and they were fully engaged in joint work with other professionals to support the child. In some YOTs, however, this work was more variable, depending on individual case managers and on the other workers. Although YOT case managers often advocated on behalf of children and challenged decisions made by children's social care services, their voice was not always heard.

### Good practice example: Focus on the wider needs of a child

Blaenau Gwent & Caerphilly YOT delivered an enhanced case management approach to complex cases, jointly funded by the Welsh Government and the Youth Justice Board. Led by a psychologist, a team of practitioners was supported over time to guide children towards changing their behaviour and moving on from offending. This approach helped professionals to focus on engagement and address priority needs, such as accommodation, as a precursor to addressing their offending behaviour.

### Good practice example: Services offering support appropriate to the needs of children

In Blaenau Gwent & Caerphilly, we saw the use of YOT staff whose specific and dedicated role was to meet and spend time with children and help them integrate into their local community facilities. The interventions concentrated on activities that were sustainable after the YOT involvement was over. They were offered separately to the offending behaviour work carried out by case managers and promoted an alternative, positive way of children spending their free time. Activities ranged from the informal, going for a walk, to more organised pastimes such as using sports facilities.

In one YOT, there were two designated accommodation workers who were knowledgeable, experienced and committed to providing the best service to children. The YOT case managers were less involved and did not take a holistic view of the child's needs, failing to properly understand when it was appropriate to deliver offending behaviour work and when other needs made it unlikely that the child would be able to effectively engage.

YOTs were less included in the assessment of accommodation needs and the planning stages, which were largely carried out by children's social care services. Too often, children's social care services did not recognise the skills of YOT workers and did not refer to the case manager for input. This was a real omission in cases where there was significant YOT involvement and could have a detrimental impact.

The assessment and management of the risk of harm that children posed to others, a key responsibility of YOTs, was not always understood or drawn on by children's social care services. YOTs were not always proactive enough in making sure that their assessments were taken into account. Where the converse was the case, we saw examples of good information sharing and joint work which was to the benefit of the child and to others with whom the child was living.

In some cases, however, particularly where a child had spent time in custody, it was the YOT which was the main agency in making sure that the child was placed appropriately.

#### **Good practice example: Effective integrated YOT work to protect other children**

Seth received a custodial sentence for serious charges of sexual exploitation of a 15 year old girl. On release, he was due to be placed in a singleton placement with 24 hour staff support. On the day of release the provider was unable to accommodate Seth as planned and placed him in a multi-occupancy building where girls assessed as being at risk of sexual exploitation were also residing. The Norfolk YOT worker visited Seth on the same day and immediately realised the risk. He contacted the provider and made sure that Seth was quickly moved.

In other instances we saw the YOT being the agency that helped to avoid the child being evicted.

#### **Good practice example: YOT work with an accommodation provider to help prevent eviction**

Dennis's parents divorced when he was four years old. He had lived with his mother until she told him to leave the family home shortly before his 17<sup>th</sup> birthday. He went to stay with his father briefly before moving into a hostel. It was during this time, after leaving home, that Dennis offended. A few weeks later, Dennis breached his bail conditions and was subsequently remanded into custody for three days. During this time a new placement was found for Dennis that had 24 hour support.

Three weeks after moving in, Dennis received a referral order. By the time Blaenau Gwent & Caerphilly YOT started to work with Dennis he was in danger of losing this accommodation as he had not applied for any housing benefit. He was falling behind with his rent and was close to being evicted. The YOT case manager and accommodation key workers (Llamau) worked to make sure that Dennis was able to remain in his accommodation, where he felt settled. The YOT helped Dennis to sort out his benefits, which allowed him to stay. With Dennis's accommodation stable, the YOT then helped him access a training course.

## **Conclusion**

Providing accommodation is not the remit of YOTs. They have, however, valuable skills to contribute to joint work with children's social care services and providers, to help children with accommodation issues. YOT case managers often had more regular contact than social workers and therefore a better opportunity to get to know and engage the child. The assessment and management of any risk that a child poses to others is part of their core business.

Where children's social care services recognised the value and skills of the YOT, and where there was an effective homelessness prevention pathway, there was good partnership working between social workers, YOT case managers and other agencies. With some exceptions, YOT case managers and YOT accommodation workers knew the children well, worked hard to engage them and were involved in working with accommodation issues. They understood that it was a priority and they focused on it, where necessary.

Overall, YOTs were making a valuable contribution in this area of work.

# Governance and oversight

## 6

## 6. Governance and oversight

### Summary

This chapter outlines the local and national structures which underpin and monitor the provision of accommodation and support services to homeless 16 and 17 year olds known to Youth Offending Teams.

### Key findings

- Locally, there was a lack of meaningful data available to understand the extent of local accommodation and support needs and provision.
- There was little monitoring of the quality of accommodation and no independent scrutiny.
- There was a tolerance of the use of unsuitable and/or unsafe emergency accommodation.
- Nationally, there was a similar lack of meaningful data and active monitoring.
- There were no sanctions for authorities failing to adhere to national guidance on suitable accommodation.

### Local governance and oversight

Accommodation and support services were provided or commissioned in various ways through local authority children's social care services, housing related support/Supporting People<sup>13</sup> commissioners and housing services.

Not all commissioners worked together locally, understood the wider needs of homeless children or monitored the provision well. Where commissioners did work together (in particular around the 18 year old 'cliff edge') and where needs were understood, accommodation and support commissioned accordingly, and provision monitored, accommodation outcomes were better.

In some places, neither commissioners nor senior managers had visited the accommodation being used for these children, despite it not being registered or regulated by Ofsted or CSSIW. This meant that nobody was checking the suitability, including the quality and security, of these placements.

Useful data and information was in short supply nearly everywhere. Monitoring was restricted to the data required by government departments. In Wales, the Supporting People programme had continued to be funded through a ring-fenced grant via the Welsh Government, with clear accountability and monitoring in place. This may have contributed to the good quality supported-accommodation which was in place in Wales. More broadly however, in both countries, there was little to evidence the level of local need or outcomes, successful or otherwise. Some local authorities had started to collect and collate information but it was not being used effectively anywhere.

More concerning, we did not find evidence of any independent local scrutiny of services to homeless children. We found no evidence that Local Safeguarding Children Boards had ever asked about the accommodation of homeless 16 and 17 year olds, even where there was unsafe accommodation being routinely used. No one was asking questions, for example, about the number of failed placements that some children experienced and what could be done to improve that situation, or how many children were placed in bed and breakfast or hostels and for how long.

<sup>13</sup> The Supporting People programme was launched in 2003 as a ring-fenced grant to local authorities intended to fund services to help vulnerable people live independently. In 2009, the ring fence was removed from the grant thereby allowing all local authorities to spend their Supporting People allocation as they deemed appropriate.

YOT management boards routinely received information about the suitability of accommodation of children on their caseloads (mandatory in Wales as a key performance indicator but on a voluntary basis in England). There was little knowledge of what **suitable** actually meant, however, and no exploration or scrutiny of the data; it was generally accepted without question.

There was a tolerance by local senior managers of the use of unsafe accommodation.

## **National governance**

The absence of key data was replicated at a national level and hence, meaningful analysis of the national picture was difficult. In Wales, we were told that collection and collation of data had recently started.

In England, housing authorities were required to report to the DCLG on a quarterly basis, the numbers of children aged 16 and 17 years old who were placed in bed and breakfast accommodation on a given date. Professionals told us that this had been instrumental in significantly reducing the use of bed and breakfast by housing authorities to accommodate homeless children.

There were 30 such children on 30 September 2015. This, however, is an incomplete picture, as there is no parallel duty to report to the DfE those placed by children's social care services. Evidence from the inspection would indicate that more children were placed in bed and breakfast accommodation by children's social care services than housing departments.

While the figures for children living in Wales were not publicly available at the time of the inspection, our findings would indicate that the proportions were higher in Wales. Data on children placed in bed and breakfast accommodation by Welsh local authorities, including children's services, will be monitored by the Welsh Government from April 2016. In England, we were told that the DCLG was currently trying to increase its understanding and seeking ways to continue to improve the present situation. We could not see that the DfE, had any ongoing, active role in making sure that 16 and 17 year olds who were not Looked After were accommodated safely.

## **Conclusion**

There was little or no independent scrutiny of the provision of accommodation to 16 and 17 year olds locally, or active monitoring nationally. Useful data was not available at either level.

Nationally, there was little evidence, in either England or Wales, that this area was a priority for action. We were told by one national representative that "*it's sorted*". In our judgment, however, although positive activity following the Southwark judgment had produced considerable improvements, this progress had now stalled.

Most concerning was the acceptance at senior levels of the use of accommodation that clearly posed a risk of harm to children and no evidence, in some places, of any action to improve that situation.

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<b>Lead Inspector</b>	Jane Attwood, <i>HMI Probation</i>
<b>Deputy Lead Inspector</b>	Helen Davies, <i>HMI Probation</i>
<b>Inspection Team</b>	Sheila Booth, <i>Care and Social Services Inspectorate Wales</i> Mary Candlin, <i>Social Care HMI, Ofsted</i> Adam Harvey, <i>HMI Probation</i> Sam Lewis, <i>Llamau (inspected in England only)</i> Mark Scott, <i>HMI Probation</i> Ian Young, <i>Social Care HMI, Ofsted</i>
<b>HMI Probation Support Services</b>	Adam Harvey, <i>Support Services Officer</i> Pippa Bennett, <i>Support Services Manager</i> Oliver Kenton, <i>Research Officer</i> Alex Pentecost, <i>Communications Manager</i>
<b>HM Assistant Chief Inspectors</b>	Helen Davies, <i>HMI Probation</i> Alan MacDonald, <i>HMI Probation</i>

# Appendices

## Appendix 1: Key guidance

### Guidance and regulations (of the *Children Act 1989*)

**Volume 3: planning transition to adulthood for care leavers (England) Suitable accommodation** provided guidance to local authorities on providing relevant children with, or maintaining them in, suitable accommodation. The guidance contained a definition of 'suitable' accommodation. Bed and breakfast accommodation was **not** considered to be suitable other than for very exceptional emergency circumstances. Such placements should be limited to a duration of no more than two working days. Local authorities should make sure that when placing children in such placements they receive appropriate supervision and contact from the authority.

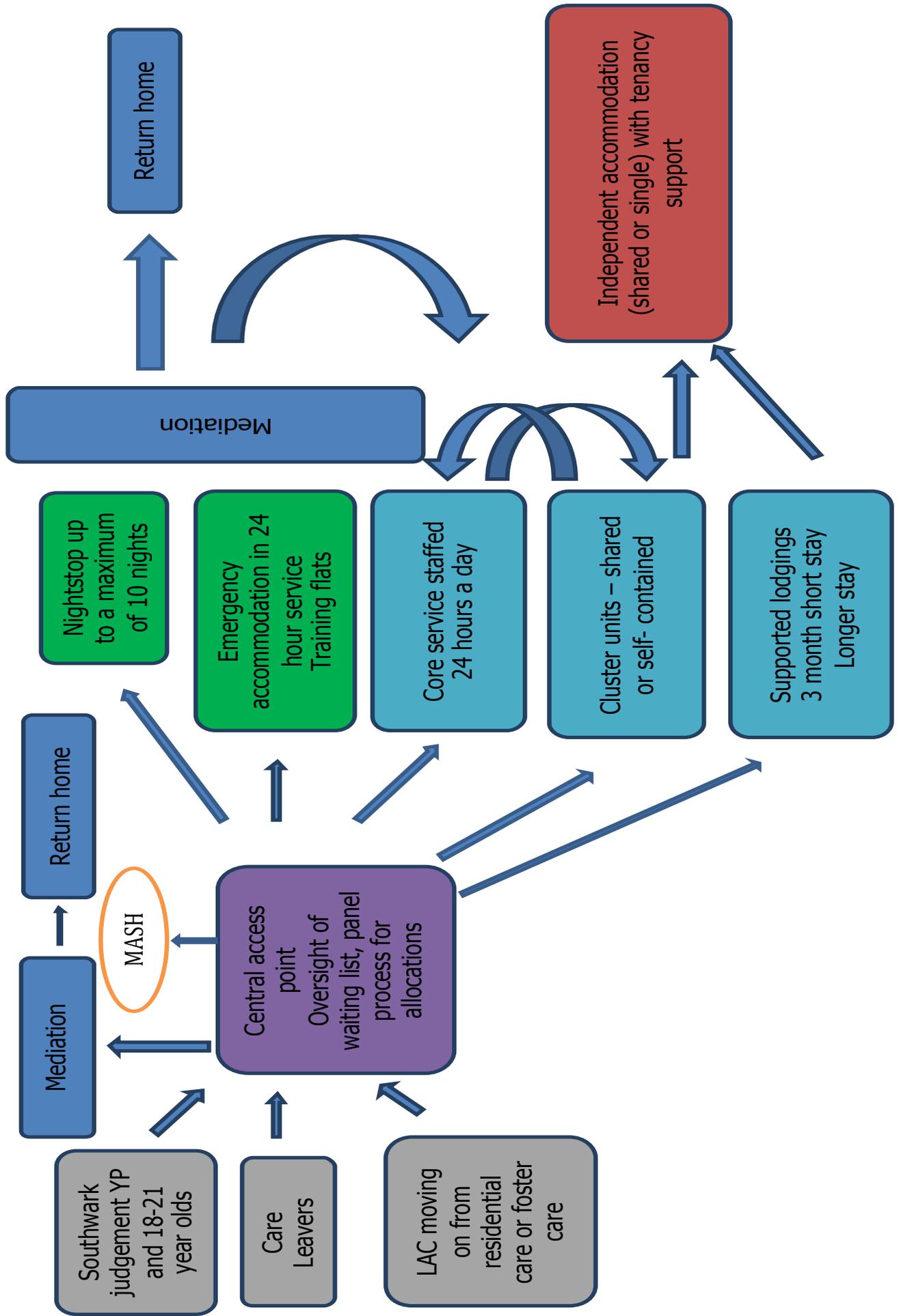
### Department for Children, Schools and Families (now the Department for Education) and Department for Communities and Local Government

**Provision of accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation 2010** provided guidance to children's social care services and local housing authorities about their duties under the *Children Act 1989* and the *Housing Act 1996* to secure or provide accommodation for homeless 16 and 17 year old children. It states: 'Where a 16 or 17 year old seeks help or is referred, and it appears he or she has nowhere safe to stay that night, then children's services must secure suitable emergency accommodation for them. This will mean that the young person will become looked after (under section 20 (1)) whilst their needs, including their need for continuing accommodation and support, are further assessed. Bed and breakfast accommodation is not considered suitable for 16 and 17 year olds even on an emergency accommodation basis'.

The Department for Education guidance goes further than the volume 3 guidance referred to above in relation to the suitability of bed and breakfast accommodation.

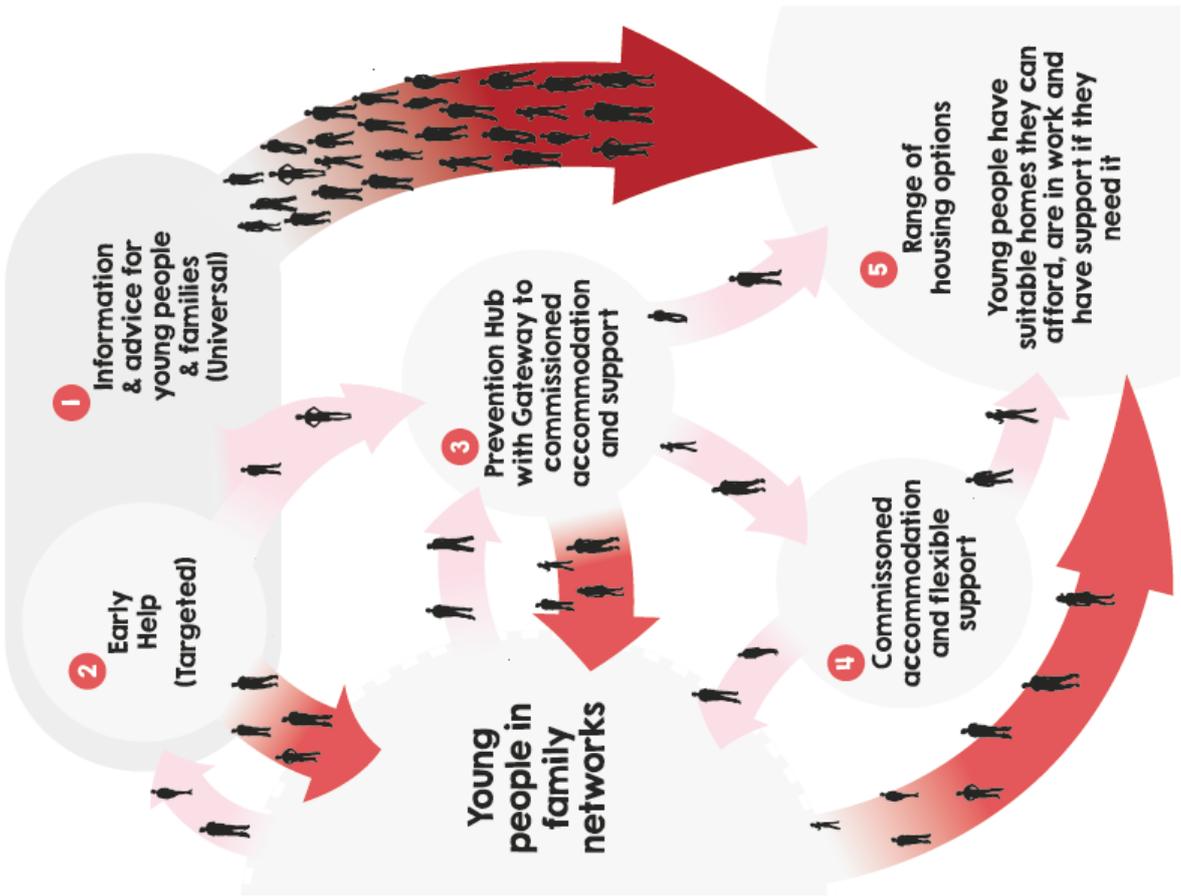
**The Welsh Government Provision of accommodation for 16 & 17 year old young people who may be homeless 2010** provided guidance on the provision of suitable accommodation for 16 and 17 year olds. It states: 'In many cases, both children's social services and housing services will need to have contact with, and provide services for, homeless 16 and 17 year olds'.

## Appendix 2: Nottinghamshire Pathway



# Appendix 3: St Basil's Positive Pathway model

## Positive Pathway Model



### Positive Pathway Framework: The 5 Service Areas

- 1 Information and advice for young people and families**  
**The Service:** Timely, accurate information and advice about housing options available to everyone, delivered in a range of ways including web-based information and through schools to reach young people, families and professionals.  
**Desired result:** Young people and families are empowered to plan transitions to independent living without support from specialist services. They understand the links between housing choice and their financial end employment situation. They know where to get help if they need it.
- 2 Early help**  
**The Service:** Early intervention targeted to reach households where young people are most likely to be at risk of homelessness, in addition to 1). Delivery involving all local services working with young people and families at risk, e.g. Troubled Families Programme, Family Support, Youth Support and Youth Offending Services.  
**Desired result:** Young people stay in the family network where possible and safe and are supported to make planned moves if they need to move out.
- 3 Integrated response ('hub' or 'virtual hub') and gateway to commissioned accommodation and support**  
**The Service:** Led by the Housing Authority and Children's Services, an integrated service for young people who are homeless, at risk of homelessness or need help with planned transitions to independence. Housing options and homelessness prevention services come together, often co-located, with other services including support for pathways into learning and work. Underpinned by assessment and including a needs driven gateway into commissioned supported accommodation and flexible housing related support services. Key data collection point to inform ongoing development of the pathway.  
**Desired results:**
  - Homelessness is prevented wherever possible, for example by supporting young people to stay in their family network or preventing the loss of a tenancy.
  - Young people who need accommodation and/or support get it, including quick access emergency accommodation and immediate and ongoing support where needed.
  - Young peoples' accommodation and support underpins rather than disrupts their pathways in learning and work.
- 4 Commissioned accommodation and support**  
**The service:** A range of accommodation and support options designed for younger and more vulnerable young people. Accommodation and support is linked together in some options, for example supported accommodation, Foyers, supported lodgings and Housing First. Flexible outreach support is also available to support young people wherever they live (including in the family home) and stick with them when they move if needed.  
**Desired results:** Young people gain the stability and skills they need, engage with learning and work and move on to greater independence.
- 5 Range of Housing Options**  
**The service:** A range of safe, decent, affordable housing options, shared and self-contained, in the private, social and third sectors. Where the market doesn't provide sufficiently for young people on low incomes the offer will need to be shaped through local housing strategies, using partnerships to create options. May include creative approaches such as partnerships with learning providers and employers to provide dedicated accommodation that underpins participation in learning and work. Access to flexible outreach support (4) in case young people need it.  
**Desired results:** Young people are economically active and have suitable homes that they can afford - they can build for their future.

## Appendix 4: Glossary

CSSIW	Care and Social Services Inspectorate Wales
DCLG	Department for Communities and Local Government
DfE	Department for education
DTO	Detention and training order: a custodial sentence for children aged 12 to 17 years old
HMI Probation	HM Inspectorate of Probation
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the <i>Children Act 2004</i> ) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England
Referral order	A statutory criminal justice order carried out in the community
Risk of harm to others	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
YOT/YOS/YJS	Youth Offending Team/Youth Offending Service/Youth Justice Service

## Appendix 5: 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:

[www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/](http://www.justiceinspectorates.gov.uk/hmiprobation/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  
1st Floor, Manchester Civil Justice Centre  
1 Bridge Street West  
Manchester M3 3FX*

### Care and Social Services Inspectorate Wales

Information on the Role of the Care and Social Services Inspectorate Wales and Code of Practice can be found on their website:

[www.cssiw.org.uk/](http://www.cssiw.org.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 Care and Social Services in Wales  
National Office, Welsh Government, Rhydycar Business Park  
Merthyr Tydfil, CF48 1UZ*

### Ofsted

Information on the Role of Ofsted and Code of Practice can be found on their 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*

