

Examining Multi-Agency Responses to Children and Young People who sexually offend

A joint inspection of the effectiveness of multi-agency work with children and young people in England and Wales who have committed sexual offences and were supervised in the community

A Joint Inspection by HMI Probation, Care and Social Services Inspectorate Wales, Care Quality Commission, Estyn, Healthcare Inspectorate Wales, HMI Constabulary, HMI Prisons and Ofsted

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Healthcare Inspectorate Wales, HMI Constabulary, HMI Prisons
and Ofsted**

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Foreword

This inspection focuses on the small but significant group of children and young people who commit sexual offences. These children and young people form a very small proportion of the overall cohort of those who offend but current estimates suggest that their behaviour could account for more than one-tenth of all sexual offending.

Their behaviour can be extremely damaging, often involving other children and young people as victims. Yet the evidence from our inspection is that these children and young people do respond to intervention from the Youth Offending Teams and can be rehabilitated before developing entrenched patterns of behaviour.

We were, therefore, very concerned to find that a sizeable number of them had been referred on previous occasions to children's social care services but the significance of their sexual behaviour was either not recognised or dismissed. This, to us, represented a lost opportunity, both for the children and young people themselves and their potential victims.

Once these children and young people had been identified and picked up by the justice system, their chances for rehabilitation dramatically improved. Many displayed a range of problems and clearly benefited from the additional attention given to their various needs and from the close working relationship they developed with the multi-disciplinary group of staff who make up Youth Offending Teams. However, the process was disturbingly slow, with cases taking on average eight months between disclosure and sentence. Although we saw many examples of good practice in direct work with young people, we found that too often the case management process supporting that work was characterised by poor communication between the relevant agencies, with inadequate assessment and joint planning.

It appears to us that the lessons learnt from working with adults about the importance of developing a shared responsibility for the early identification and management of high risk cases across *all* the agencies involved, manifest in comprehensive, coordinated, multi-agency work, have still to permeate work with children and young people. Some basic improvements in process would bring considerable dividends. This report contains a number of recommendations to promote that end.

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Contents

	Page
Acknowledgements	3
Foreword	4
Contents	5
Summary of findings	6
Recommendations	9
1. Context	11
2. Purpose of the inspection and methodology	15
3. The journey from disclosure to sentence	20
4. Completion of assessments and developing plans	26
5. Delivering interventions	31
6. Achieving and evaluating outcomes	38
Appendix 1: Glossary	42
Appendix 2: Role of the inspectorates and code of practice	44
Appendix 3: References	46

Summary of findings

The inspection

This inspection of multi-agency work undertaken with children and young people convicted of sexual offences was agreed by the Criminal Justice Chief Inspectors' Group as part of the *Joint Inspection Business Plan 2011-13*. Its terms of reference were:

- to examine the quality of the assessment, planning, interventions and outcomes for children and young people who sexually abuse and are supervised within the community.

The focus of the inspection was on the quality of the work undertaken with these children and young people and its outcomes - how the different agencies worked together and what had been achieved. During the course of the inspection we visited six Youth Offending Teams and examined a total of 24 cases in depth including one final warning case and four custody cases where the child or young person had now been released into the community. We followed each child or young person's journey from disclosure of the offence through to supervision in the community.

Disclosure to conviction

The average time period between the disclosure of the offence and the sentence of the child or young person concerned was eight months. This was unacceptably long and resulted in lengthy periods, especially where the offence was initially denied, when little or no work was done with the child or young person accused of the offence. Little consideration was given to where these children and young people 'fitted' into children's social care services, or why they had committed the offence, especially when the sexually harmful behaviour was denied. As a result, neither their potential risk of harm to others nor their safeguarding needs were sufficiently assessed or managed. Several of the children and young people had previously come to the notice of the authorities, sometimes on a number of occasions, either for sexually harmful behaviour or other concerns, but we saw little evidence of work having been undertaken to address their behaviour. Opportunities had been missed for early intervention which may have reduced the risk of sexual offending.

We were surprised to find that some workers in the cases in our sample were reluctant to share information with education establishments, fearing that this might be detrimental to the child or young person. Schools are a rich source of information about a child or young person's behaviour, but in the cases examined were rarely included in multi-agency strategy discussions or subsequent meetings. The contribution of the health services varied considerably too, despite significant needs having been identified in the cases inspected.

Responses were better where those dealing with referrals had specialist knowledge or training regarding children and young people who displayed sexually harmful behaviour.

Assessment and planning

We found very few examples where holistic, multi-agency assessments had been undertaken and shared. The underlying reasons or triggers for the sexual offending were consequently not fully analysed in many of the cases inspected. Pre-sentence reports were prepared in only half of the cases we inspected. Completion of health assessments was inconsistent and, where they were undertaken, rarely shared with other professionals. Few assessments were undertaken prior to sentence by specialists working with adolescents engaged in sexually harmful behaviour and often took a long time to complete. Workers from other agencies were generally not invited to

contribute to such assessments and it was rare to find that a multi-disciplinary meeting had been held on its completion to take forward the work identified as necessary. There was a lack of robust quality assurance of assessments.

Significant gaps in communication and information sharing emerged throughout the assessment and planning processes. Where children and young people were managed through a formal process such as child protection, Multi-Agency Public Protection Arrangements or as a result of being a Looked After Child, we saw better evidence of joint planning, communication and integration of plans.

We were pleased to see that children and young people and their parents/carers had been involved in assessments and understood the roles and responsibilities of the various workers. Although diversity needs were assessed they were not often addressed within plans.

Interventions

Positive examples of holistic multi-agency interventions to address the many needs of this group of children and young people in our sample were rare. Most of the work to address offending behaviour was not delivered as identified in various plans, and interventions were not always informed by assessments. Multi-agency interventions often lacked coordination. Initial denial of sexual offending proved to be a major barrier to the provision of effective interventions, although we did see some examples where 'The Good Lives Model', an approach which focuses on the child or young person's strengths, goals and aspirations, had been used to good effect.

Where health and education had contributed effectively to the assessment process, we saw some excellent interventions delivered by these workers. We also found good examples of family support work, but saw little evidence of action to address the complex family situation in which some of the children and young people were living or work linked directly to sexually harmful offending.

The standard of management oversight and supervision varied considerably, with insufficient challenge to the quality and appropriateness of interventions.

Communication and information sharing was again a major theme. Youth Offending Team staff appeared confused about the role of Multi-Agency Public Protection Arrangements, its thresholds and which children and young people should be subject to registration requirements. In our view, only a few of cases were serious enough to reach the Level 2 threshold so most were managed at Level 1. In these cases, information sharing and joint planning was effective where routine multi-agency meetings were held.

Outcomes

The majority of the children and young people in the sample had a wide range of complex needs. Despite our concerns at the quality of the case management process (the timeliness and quality of assessments and the coordination of joint work), the children and young people in our sample clearly benefited from the child-focused practice adopted by the individual workers who supervised them. By establishing positive working relationships with the children and young people they supervised, workers were able to address their needs as vulnerable adolescents while still focusing on the risks they presented to others. Most of the children and young people complied with their order and engaged well with the work undertaken to address their offending. From reading the cases and talking to a range of staff, we were able to establish that only one child or young person had been convicted of a further sexual offence.

Progress had been made against the most significant factors related to offending in over half of the cases and in ten cases protective and positive factors had been developed. Many had

attained qualifications, developed positive relationships, improved relationships with parents/carers, obtained and sustained independent accommodation, learned strategies to manage anxiety and depression as well as developing conflict resolution skills.

It was therefore frustrating that such good achievements were not better supported by the case management process. As a result we could not be confident that risk of harm to others had been effectively managed in the vast majority of cases. We were left with the worrying concern that interventions could have taken place earlier and more could have been achieved, or that what had been achieved could be more easily sustained, if the quality of the work maintaining these outcomes had been better.

Given what appeared to be some successful outcomes, we were surprised to see little evidence of any routine evaluation at a strategic level of the quality or effectiveness of multi-agency work. Only specialist services undertook systematic reviews of the impact and effectiveness of their interventions with individuals through the completion of psychometric or other measures.

We saw some excellent examples of services provided to victims, but many were not offered a service or only provided with help after conviction. This is not acceptable, given the long time between disclosure and sentence. Victims' safety was not always given sufficient attention although schools and colleges undertook some good work to manage the safety of the child or young person and potential victims. We did, however, find some good examples of work undertaken to enable the child or young person to understand the impact of their behaviour on victims.

Overall comment

Children and young people who sexually offend form a very small proportion of the overall cohort of those who offend but the impact of their behaviour can be extremely damaging, and often affects other children and young people. We would expect the existing formal bodies with responsibility for oversight of such work, such as the Youth Offending Team Management Board or the Local Safeguarding Children Board, to take a proactive role in monitoring and evaluating the effectiveness of the multi-agency work. We saw little evidence of this and as a result have made recommendations to both of these boards.

Although the outcomes achieved in many of the cases were promising, the lack of comprehensive, coordinated multi-agency work was concerning. In some cases, the multi-agency meeting arranged as part of the inspection process was the first occasion that all the parties involved with that child or young person had met. We saw some effective interventions, but too often delivered in a piecemeal fashion. A number of areas had developed specific procedures and/or protocols but the gaps between policy, process and practice were significant and impacted on the quality of work to manage risk of harm to others. We found no evidence at a strategic level that implementation had been monitored or reviewed. More could be achieved by addressing these issues.

Almost half of the cases (11) we looked at contained documented evidence of previous sexualised behaviour. This was either not identified as such at the time, or too often subject to disbelief, minimisation and denial by professionals as well as families and treated as a 'one-off'. Consequently, the child or young person concerned was not subject to interventions to try to avert such behaviour in the future. Given that in this inspection, interventions, if successfully delivered, appear to have a positive effect, help delivered earlier may prevent other children and young people from becoming victims in the future.

Recommendations

All agencies should:

- from disclosure to the end of sentence, actively contribute to timely information sharing and assessments to both inform decision making and, where appropriate, deliver interventions so that further incidents of sexually harmful behaviour/offending can be prevented at the earliest possible stage.

The Youth Justice Board should:

- regularly disseminate (and where possible commission) information about current research to Youth Offending Teams so that Youth Offending Team practitioners undertake assessments and deliver interventions which are underpinned by a clear evidence base,
- help other sectors understand the specific risk issues relating to children and young people who commit sexual offences against other children and young people,
- identify the appropriate risk assessment tools to be used by the Police/Youth Offending Teams in such cases.

The National Offender Management Service – Multi-Agency Public Protection Arrangements should:

- promote greater consistency and improvements in work with children and young people who pose a serious risk of harm to the public by ensuring that Multi-Agency Public Protection Agency Chairs and coordinators recognise the importance of seeking specialist knowledge and advice about the potential risk of harm factors of children and young people who commit sexual offences.

Local Safeguarding Children Boards should:

- promote effective joint work with children and young people who display, or are likely to develop, sexually harmful behaviour by:
 - ensuring that in the Early Help Strategy the needs of children and young people who display, or are likely to develop, sexually harmful behaviour are identified and recognised, and that they are provided with help and intervention at the earliest possible opportunity,
 - monitoring the effectiveness of the multi-agency response to such children and young people in their area, particularly including the identification of such cases, joint assessments and the interventions to them and their families and, where appropriate, their victims,
 - developing and implementing strategies to address apparent deficits,
 - establishing open channels of communication with the local Multi-Agency Public Protection Arrangements Chair and coordinator in cases where there is a shared interest.

Youth Offending Team Management Boards should:

- seek assurance that timely specialist multi-disciplinary assessments of sexually harmful behaviour are undertaken and shared with relevant agencies,
- ensure that appropriately targeted, evidence based interventions informed by a full assessment of needs of the child or young person are available,
- ensure that Youth Offending Team case managers are familiar with the Multi-Agency Public Protection Arrangements guidance so that they understand the role of Multi-Agency Public Protection Arrangements, the requirements for Multi-Agency Public Protection Arrangements registration and the thresholds for referral into Level 2/3 for children and young people convicted of sexual offences,
- ensure that YOT case managers take a lead role in working with police offender managers to improve communication links and to develop, with others, joint public protection management plans for children and young people who have offended,
- confirm that appropriate services to victims are offered at the earliest possible stage.

Health representatives on Youth Offending Team Management Boards should:

- ensure that comprehensive health assessments including cognitive assessments are completed consistently on these cases so that relevant information is shared, needs are met and the delivery of effective interventions is coordinated and evaluated.

Police services should:

- ensure the effective use of police officers to support the full range of Youth Offending Team responsibilities including routine information sharing, risk assessment and management,
- ensure police offender managers work closely with Youth Offending Team case managers to improve communication links and to develop, with others, joint public protection management plans for children and young people who have offended and, where key actions are identified, these are assigned to the appropriate agency.

1. Context for the inspection

Introduction

- 1.1 The inspection was informed by a body of research about assessment and interventions, in addition to studies exploring the range and effectiveness of responses to children and young people exhibiting sexually harmful behaviour¹. Although the research is largely inconclusive regarding the effectiveness of specific assessment tools or types of intervention, consensus exists in the literature about the need for a multi-disciplinary approach to meeting the needs of the child or young person.

Prevalence and recidivism

- 1.2 Ministry of Justice statistics from 2011/2012 indicate 12.4% of all those cautioned or convicted for a sexual offence were between 10 and 17 years old. Various retrospective studies suggest that around one-quarter of all alleged sexual abuse involves young, mainly adolescent, perpetrators. In terms of sexual recidivism, rates for children and young people are much lower than for adults who commit sexual offences and fall between 5% and 14%. Non-sexual recidivism rates, however, are higher at between 16% and 54% (*Estimate of Risk of Adolescent Sexual Offense Recidivism (Version 2.0: The "ERASOR")*, Worling & Curwen, 2001; *A prospective longitudinal study of sexual recidivism among adolescent sex offenders*, Nisbet, Wilson & Smallbone, 2004; and *Juvenile Sex Offender Re-Arrest Rates for Sexual, Violent Nonsexual and Property Crimes: A 10-Year Follow-Up*, Waite, Keller, McGarvey, Wieckowski, Pinkerton & Brown, 2005).
- 1.3 Sexual recidivism is associated with a variety of developmental, social and criminological factors but few studies identify those characteristics that are able to predict which children and young people are likely to continue sexual offending into adulthood. Denial is not a significant factor. There is currently no scientifically validated system to determine which children and young people who sexually offend are most likely to pose a high risk of sexual recidivism.

Effective approaches to working with children and young people who commit sexual offences

- 1.4 Until the 1990s, approaches to assessing and working with children and young people who had committed sexual offences or engaged in sexually harmful behaviour was primarily based on work with adult sex offenders. Over the last decade, there has been a growing recognition that these approaches are not directly transferable to work with children and young people, primarily because they fail to take account of the child or young person's maturation. Practice should remain child or young person centred and interventions delivered that address the needs of the whole child or young person.
- 1.5 The *Report of the Committee of Enquiry into Children and Young People who Sexually Abuse other Children* published by the National Children's Home (NCH)² in 1992, found significant gaps in the response to these children and young people. The report highlighted a lack of consistent and coordinated approaches, an absence of intervention

¹ Sexually harmful behaviours cover a wide spectrum of behaviour with not all cases meeting the threshold to result in a conviction

² National Children's Home was renamed Action for Children.

services and inadequate training, supervision and consultancy. It made a number of recommendations including:

- the need for courts to obtain an assessment prior to sentencing;
- the development of a systematic approach to dealing with young people located within the child protection system;
- the availability of intensive treatment in custody;
- the development of a 'continuum of care' involving a range of agencies as well as a network of specialist services; and
- the availability of training and supervision for staff working with these children and young people.

1.6 *Working Together to Safeguard Children* (Department of Health, Home Office and Department for Education and Employment 1999) outlined three principles to guide the work:

'there should be a co-ordinated approach on the part of youth justice, child welfare, education (including educational psychology) and health (including child and adolescent mental health) agencies; the needs of children & young people who abuse others should be considered separately from the needs of their victims; and an assessment should be carried out in each case, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour'.

1.7 In 2004, a survey of Youth Offending Teams (YOTs) in England and Wales by Masson and Hackett reviewed the extent and nature of YOT responses to adolescents exhibiting sexually problematic behaviour. Inconsistencies were apparent between areas in relation to the development of specific policies, procedures and protocols specifically referencing provision of services for children and young people who had sexually abused, as well as the use of child protection conferences, multi-agency meetings and the effective use of Multi-Agency Public Protection Arrangements (MAPPA). Nearly half of the YOTs *'thought that the continuing separation of child welfare and youth crime systems of response hindered effective working together'*³. Concerns were expressed about the lack of availability of assessment services, lack of access to forensic psychiatry or psychology services and poor coordination across assessment services. Intervention approaches reported at the time were based on cognitive behavioural work, relapse prevention, family and psycho-educational approaches.

1.8 The Youth Justice Board (YJB) publication *Services for Young People Who Sexually Abuse: A report on mapping and exploring services for young people who have sexually abused others* in 2005, highlighted that services had developed since the NCH report in 1992. A series of recommendations were made relating to:

- the development of a national strategy;
- the need for further evaluation research and guidance to promote best practice;
- the availability of best practice guidance based on current research findings;
- the national guidance to address effective work across child welfare and youth justice systems;
- the clarification of referral routes and funding for specialist assessments; and
- the development of accredited training and provision of effective supervision and support.

³ *The Extent and Nature of Work with Adolescents Who Have Sexual Behaviour Problems: Findings from a Survey of Youth Offending Teams in England and Wales*, see the references section for further details.

- 1.9 In 2008, the YJB published *Key Elements of Effective Practice: Young People who Sexually Abuse (KEEP)* which identified the key indicators of quality in relation to children and young people who sexually abuse and provides guidance for assessment and service delivery as well as strategic and operational management, partnership working, service development and monitoring/evaluation of services.
- 1.10 The *All Wales Child Protection Procedures 2008* provided more specific guidance, advising that there should be a coordinated approach to allegations of sexual abuse by children and young people that involves the YOT as well as social services, police, education services (including educational psychology and education welfare), the health service (including Child and Adolescent Mental Health Service (CAMHS)) and specialist harmful behaviour services where available. There is currently a South Wales Child Protection Forum Protocol - *Young People who Sexually Harm: Protocol for the management of children and young people who display sexually harmful or sexually offending behaviour* that relates specifically to children and young people who sexually harm. It is intended that this will become an All Wales Protocol to ensure consistency in the management of these children and young people across Wales (see 1.12).
- 1.11 In England, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, published in 2010 recommends that a child protection conference should be held if the child or young person was considered to be at risk of significant harm, otherwise a multi-agency meeting should be convened. The guidance also reinforced the need for a coordinated approach between youth justice and child welfare agencies.
- 1.12 The Welsh Government has commissioned the All Wales Child Protection Procedures Review Group in collaboration with Barnardo's Cymru to produce an All Wales Protocol on Sexually Harmful Behaviour. The protocol will seek to promote a consistent approach across the agencies working in Wales with children and young people whose behaviour has caused concern. It is anticipated that this protocol will be published shortly.

Key messages from the research assessment

- 1.13 Research indicates that assessments should be multi-faceted and address the whole range of needs, strengths and risks presented by the child or young person. All agencies should be involved and the assessment should be based upon a comprehensive range of sources. Additionally, parents/carers should be fully consulted during the assessment process and the assessments and plans shared and agreed across agencies.
- 1.14 Although there are no validated assessment tools for use with children and young people who commit sexual offences, specialist assessment tools do appear to show a higher level of accuracy in predicting sexual recidivism than non-specialist assessments. Tools such as Assessment, Intervention and Moving On 2 (AIM); Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II); Juvenile Sexual Offence Recidivism Risk Assessment Tool-II (J-SORRAT-II); Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR) should therefore be used in addition to core assessment tools such as ASSET (the YJB structured assessment tool for children and young people who offend).
- 1.15 The YJB KEEP Guidance reinforces the need for a common assessment model to *'help to ensure that the maximum valid information is known which, when integrated, will help to shape and inform a graduated inter-agency response'*.
- 1.16 Children and young people with learning difficulties are overrepresented in those who display sexually harmful behaviour and no validated assessment tools exist for working with children and young people with learning, speech, language or communication issues.

AIM2 has been adapted for use with those with learning difficulties and good practice would suggest that a cognitive assessment is a prerequisite prior to an assessment being undertaken.

Interventions

- 1.17 A range of different types of interventions have been developed to work with children and young people who commit sexual offences. However, there is little evidence to suggest that any one single approach works. The effective practice principles relating to interventions remain relevant to this group of children and young people who offend and interventions should therefore be tailored to meet individual risks, needs and responsivity factors. The literature emphasises that interventions should be holistic, multi-modal and should not rely on one approach. Work in relation to sexual offending with both the child or young person and their family is important. As the rate of reoffending is higher amongst those who do not complete interventions, whatever interventions are delivered, they should be delivered as intended and completed.
- 1.18 Research into the effectiveness of different treatment approaches is inconclusive; however, there is strong evidence that interventions to address sexually harmful behaviour should be targeted to the specific needs of the child or young person and appropriate to the type of behaviour displayed. 'The Good Lives Model', a strengths based rehabilitation model which focuses on the child or young person's interests, abilities and aspirations, is widely used and a recent national evaluation is exploring the use of Multi-Systemic Therapy with children and young people who sexually abuse⁴.
- 1.19 The YJB KEEP guidance identifies the following intervention components which they suggest will be effective in tackling sexual offending:
- Emotional competence skills;
 - General developmental assessment;
 - Changing cognitive distortions about sex and relationships;
 - Pro-social, emotional, cognitive and behaviour skills;
 - Risk assessment;
 - Gaining an understanding of the child's cycles/pathways to sexually harmful behaviour;
 - Sex education,
 - Life-space work(boundaries, social skills, interaction);
 - Relapse prevention work;
 - Family work;
 - Consequences of further abuse/behaviour; and
 - Developing empathy.

Summary

- 1.20 The inspection was looking for evidence of a clear and explicit strategic approach to children and young people who commit sexual offences which facilitated holistic multi-agency assessments and led to a range of interventions, based on effective practice, which met the complex needs of the child or young person in order to reduce the likelihood of reoffending and protect their victims.

⁴ Brandon Centre, University of Central London – not yet published.

2. Purpose of the inspection and methodology

Scope of the inspection

2.1 This inspection of multi-agency work undertaken with children and young people convicted of sexual offences was agreed by the Criminal Justice Chief Inspectors' Group as part of the *Joint Inspection Business Plan 2011-13*. The inspection was led by HM Inspectorate of Probation (HMI Probation) and supported by HM Inspectorate of Constabulary (HMI Constabulary), Ofsted and the Care Quality Commission in England. In Wales, the Care and Social Services Inspectorate Wales, Estyn and the Healthcare Inspectorate Wales undertook the fieldwork alongside HMI Probation and HMI Constabulary in Wales. HM Inspectorate of Prisons (HMI Prisons) undertook a survey of 11 prison establishments to identify provision for children and young people in custody convicted of sexual offences.

The terms of reference were:

- to examine the quality of the assessment, planning, interventions and outcomes for children and young people who sexually abuse and are supervised within the community.

Purpose of the inspection

2.2 The inspection focused on the effectiveness of the multi-agency response to children and young people who had received a sentence for a sexual offence and were being supervised in the community in England and Wales. It examined the quality of the work undertaken with these children and young people and its outcomes - how the different agencies had worked together and what had been achieved.

Methodology

2.3 During the course of the inspection we visited six YOTs between April and June 2012 and examined a total of 24 cases, following each child or young person's journey from disclosure of the offence through to supervision in the community to find examples of good multi-agency work at both operational and strategic level and to identify what facilitated effective, coordinated approaches. Areas were selected to include a range of both rural and urban locations, different models of delivery, and areas where children and young people with sexual offences represented either a relatively high or low proportion of the caseload. In addition, HMI Prisons undertook a survey of 11 prison establishments to identify provision for children and young people in custody convicted of sexual offences.

2.4 In order to review the quality of multi-agency arrangements and work, structured group interviews were undertaken which involved all inspectors meeting with all of the professionals involved in the case. We also undertook individual interviews with professionals, children and young people and their parents/carers. Key strategic managers across a range of agencies including, social care, health, police, probation, education as well as MAPPA Strategic Management Board and Local Safeguarding Children Board (LSCB) Chairs were also interviewed. The inspectorate team were provided

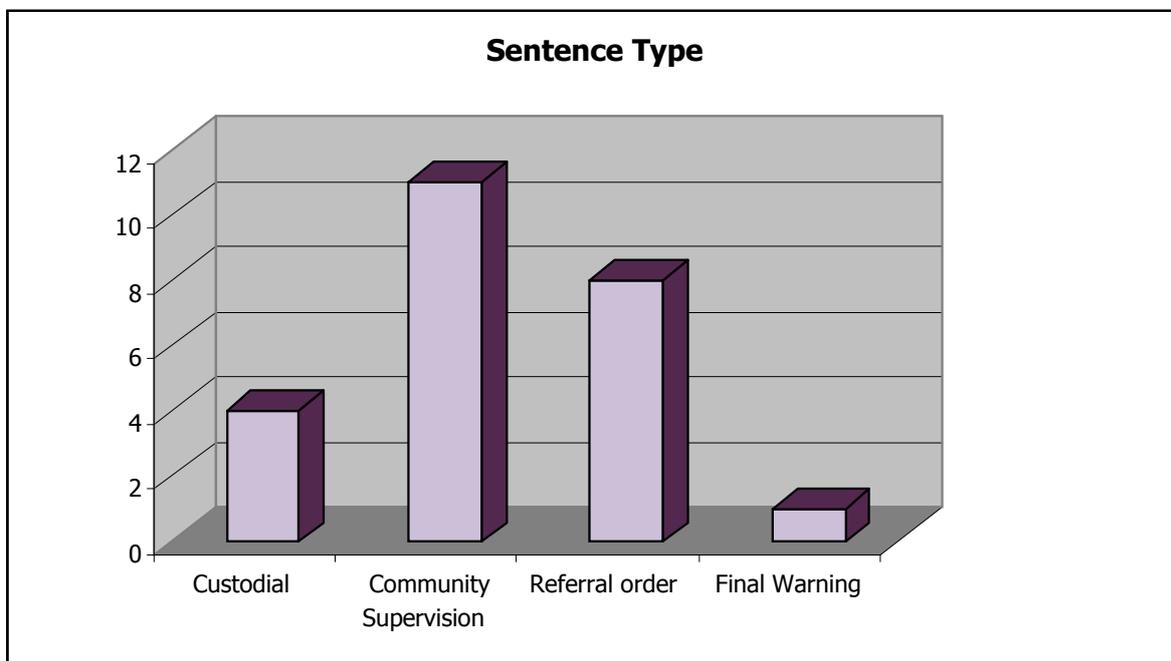
with a pen picture which included core information about the child or young person and case files were reviewed by the respective inspectorates prior to the group interview.

The case sample profile

2.5 We reviewed the cases of 24 children and young people, all of whom were male and aged between 13 and 18 years old. No girls met the criteria for inclusion in the sample within the YOTs visited.

- Ten of the children and young people were under 16 years.
- One child or young person received a Final Warning, the other 23 children and young people had been convicted of a total of over 60 offences against other individual children and young people with the exception of one offence which was against an adult.
- The most common offence was sexual assault.
- Seven of the young men (29%) had previous convictions, although only one had been previously convicted of a sexual offence.
- Four had numerous previous convictions for a range of non-sexual offences but the majority had no previous convictions.
- In eight cases, previous incidents of sexually harmful behaviour and in two further cases previous concerns came to light after conviction.
- Two young men had disclosed their own experience of sexual abuse.

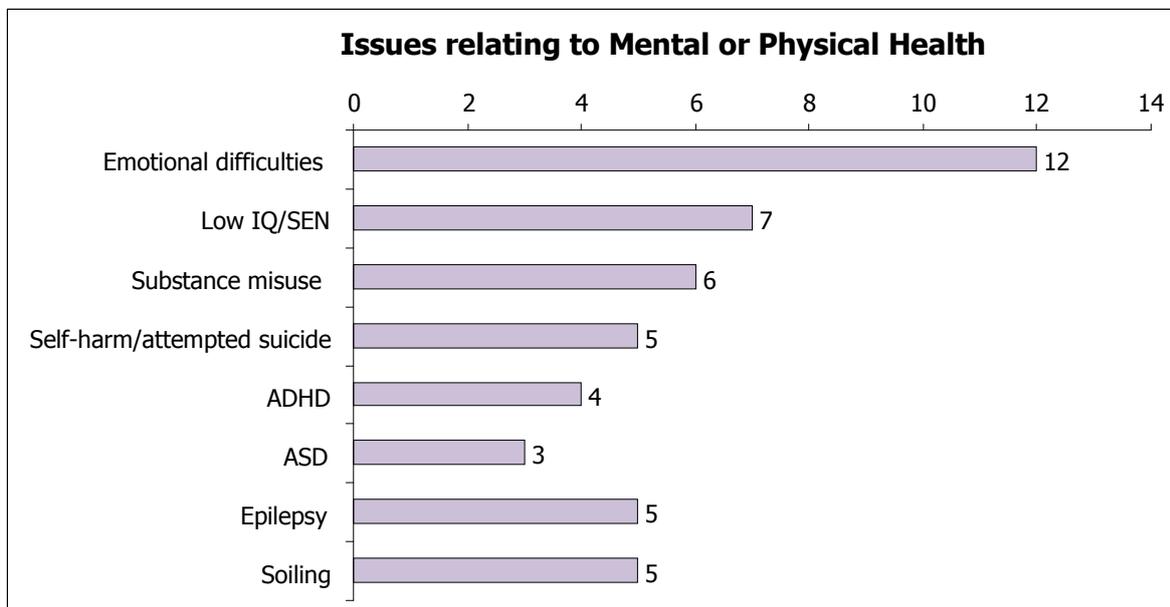
Sentence Type



2.6 Most young men within the sample had been sentenced to community based orders and for many the sexual offence was their first contact with the criminal justice system.

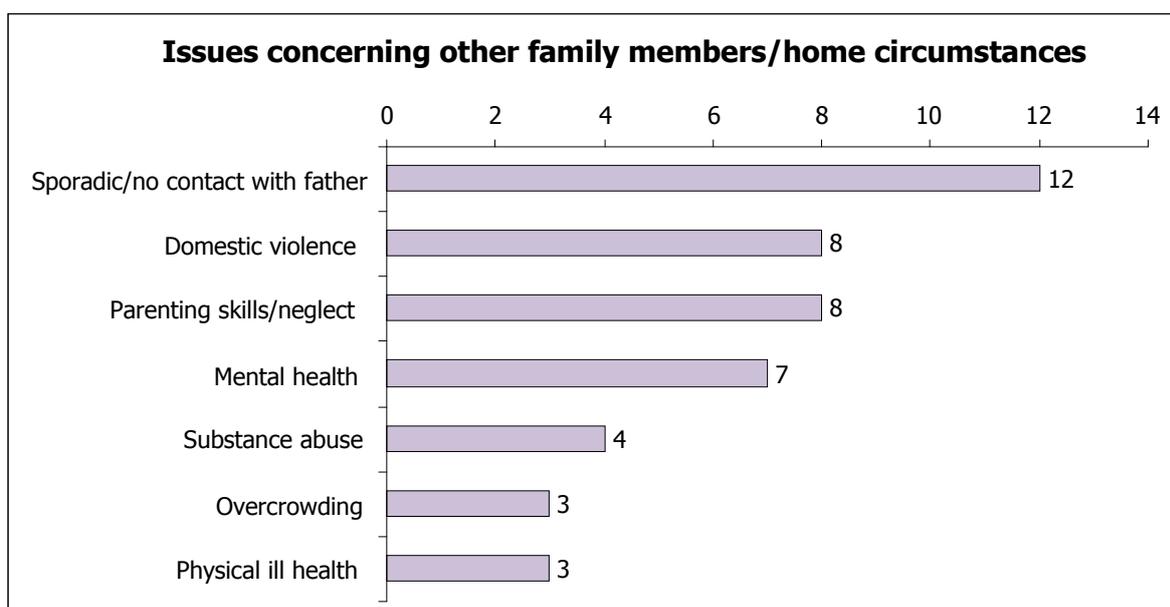
Physical/emotional concerns

- 2.7 In 21 out of the 24 cases, issues had been identified relating to either the physical or mental health of the children and young people, although not specifically diagnosed in several of the cases. In some cases, apparently with 'no learning disabilities', further information suggested the existence of previously unidentified underlying disorders. This reinforces the need for a thorough cognitive assessment prior to specialist sexual behaviour assessments. Two young men had a statement of special educational needs.



Family/home environmental factors

- 2.8 In 21 cases concerns, which varied from minor to very substantial, were identified relating to the family or home environment. These concerns had not always been evident before the offence and even when recognised, had not triggered any intervention so had not been addressed. Several children and young people were carers for other family members.



2.9 In summary, all except one child or young person had previous or current concerns related either to: physical or emotional health (21); previous offending (7); previous sexualised behaviour (11); family/home environment (21); or concerns which led to the involvement of children's social care (12). Ten of the young men had issues relating to four or more of these factors. A clear picture emerges of young men who had multiple and complex needs in addition to their sexual offending.

What we were looking for...

2.10 The inspection criteria addressed four key areas; strategic arrangements, assessment and planning, delivery of interventions and outcomes.

Strategic arrangements

2.11 We inspected the extent to which strategic arrangements facilitated an effective, coordinated multi-agency approach to address the complex needs of children and young people who commit sexual offences as well as protecting their victims. In particular, we focused on the effectiveness of information sharing protocols, the availability of appropriately trained and supported staff across agencies, and the extent to which local arrangements are supported, reviewed and monitored across key multi-agency partnerships.

Assessment and planning

2.12 The inspection reviewed whether there was an agreed inter-agency framework for the referral and appropriate specialist assessment of children and young people who committed sexual offences which resulted in an agreed multi-agency plan to manage risk of harm to others, likelihood of reoffending and vulnerability as well as developing strengths and protective factors such as education, health, family support and positive lifestyles. Most importantly we reviewed the effectiveness of information sharing and communication between agencies.

Interventions

2.13 We reviewed whether effective use was made of a range of multi-agency interventions which are appropriate to the specific needs of the children and young people who commit sexual offences, their families, parents/carers and victims. Also whether interventions were appropriate to assessed risks, needs and sexually harmful behaviour, delivery was coordinated and reviewed and whether approaches were identified to promote positive factors.

Outcomes

2.14 We examined the extent to which multi-agency interventions had a positive impact in reducing reoffending, addressing safeguarding needs, and protecting victims and the public. We were looking for evidence that multi-agency partnerships had evaluated the effectiveness and impact of the services provided to these children and young people in order to inform the development and commissioning of service.

Summary

2.15 We were looking to find examples of best practice across a range of different arrangements in six authorities in England and one in Wales. We were interested in how strategic arrangements facilitated effective, coordinated work across the agencies and how these were reviewed and monitored. At operational level we wanted to find out how well the agencies worked together from disclosure through to supervision in the community, particularly in relation to completion and sharing of assessments, planning and delivery of interventions and to find out what had been achieved.

3. The journey from disclosure to sentence

Key Themes

- Opportunities for early intervention on a range of issues were missed in nearly every case when signs or concerns had not been recognised, understood or acted upon.
- The strategic approach following disclosure varied considerably, with a general lack of understanding as to where these children and young people 'fitted' into the system and confusion about how to effectively respond to their needs and risks.
- Significant delays occurred between disclosure and conviction, impacting on all involved. Usually, neither the child or young person accused of the offence nor their alleged victim received any support until after sentence.
- Initial and core assessments paid insufficient attention to earlier referrals about inappropriate sexualised behaviour and often failed to consider the relevant past history of the family or whether the child or young person had themselves been a victim of sexual abuse.
- We saw many good examples of schools playing a significant role following disclosure, undertaking risk assessments and putting risk management plans in place prior to conviction, but often in isolation.
- Information sharing across the agencies between disclosure and sentence was generally poor, resulting in inaccurate or incomplete assessments.
- Until an admission or finding of guilt, there was little proactive risk assessment or management, a concern given the length of time between disclosure and conviction.

Missed opportunities for early intervention

- 3.1 We found that opportunities for early intervention to address emerging concerns had been missed, some of these in schools. In eight cases there had been previous concerns about sexualised behaviour but often these or other concerns had not been recognised, understood or acted upon either because a threshold had not been met or because referrals were viewed in isolation. Questions were not asked at this stage why the child or young person was displaying sexualised behaviour, some from quite a young age. This often resulted from limited enquiries by social workers at that time, (who may have received no specialist training and lacked understanding of the specific risks). Despite this lack of specific training, we found it surprising that social workers' general training about child development and learnt behaviour did not lead to them being more questioning, asking themselves 'why is this child or young person exhibiting sexualised behaviour?'

Concern had been expressed about Bradley's⁵ sexually inappropriate behaviour since he was eight years old. He had been referred to both children's social care services and the police several times and on one occasion charged with an offence, which was subsequently discontinued. There was no evidence of any strategy discussions or meetings until Bradley was eventually convicted of an offence at the age of 16.

⁵ All names used in the case examples have been altered

- 3.2 Over half of the children and young people in the sample had previous involvement with children's social care services. Six had been subject to child protection plans or had been looked after prior to the offences, but the possibility that even these children and young people, in routine contact with children's social care services, had been victims of sexual abuse was often not recognised. Concerns were recorded in the case files about a number of the children and young people, some dating back many years, but the significance of their sexualised behaviour was too often either ignored or denied.

Children's social care services had been involved with Joel for over 15 years and he had been subject to a child protection plan on numerous occasions for neglect and physical abuse. Records indicated that concerns existed that he had been the victim of sexual abuse which together with the history of family sexual abuse and presence of adult sex offenders in the home should have triggered an investigation. Interventions had not been proactive and he had not always been assigned an allocated social worker.

Joel told us "*I should have been looked after from the age of 10 and then I wouldn't have done what I did*".

Strategic coordination

- 3.3 Strategic partnerships were generally well embedded with good levels of representation at key strategic meetings across most agencies. In the midst of significant restructuring of health provision, achieving appropriate levels of representation was problematic in some areas. Whilst strategic plans (LSCB/Children's Trust) included priorities in relation to child exploitation and vulnerable children and young people or children and young people who had offended, no reference was made to children and young people who display sexually harmful behaviour. Four areas had developed specific policies or procedures regarding the management of children and young people who sexually abused but we found little evidence that these policies had been put into practice. Given that Ministry of Justice statistics from 2011/2012 indicated that 12.4% of all those cautioned or convicted for a sexual offence were between 10 and 17 years old, we would have expected that LSCBs or MAPPA Strategic Management Boards had taken a proactive role in assuring themselves of the effectiveness of multi-agency work or policies in relation to these children and young people. Neither were they aware of the numbers of children and young people displaying sexually harmful behaviour in their local area.

The South Wales Child Protection Forum Protocol for the management of children and young people who display sexually harmful or sexual offending behaviour, revised 2010, is a comprehensive document which outlines the agreed multi-agency response to children and young people under the age of 18 displaying sexually harmful behaviour and states that they should be managed consistently, regardless of whether or not they are to be prosecuted. The protocol addresses actions required at referral, the role of the multi-agency strategy meeting which must be held for every case and describes how the needs and risks of the child or young person and their victims or potential victims should be coordinated either through child protection or Child in Need plans.

South Wales Child Protection Forum as seen in the **Vale of Glamorgan**.

- 3.4 Typically, children and young people who commit sexual offences were not a priority for strategic managers or boards as they represented relatively small numbers. There appeared to be an over reliance on exception reporting or serious incidents to highlight concerns.

One MAPPA Senior Management Board Chair stated:

"The numbers of children and young people with sexually harmful behaviour is not considered by the strategic management board (SMB) nor is any associated level of offending. There is complacency about the nature and extent of the problem in the area and no inclination to consider the potential impact on the public of such offending."

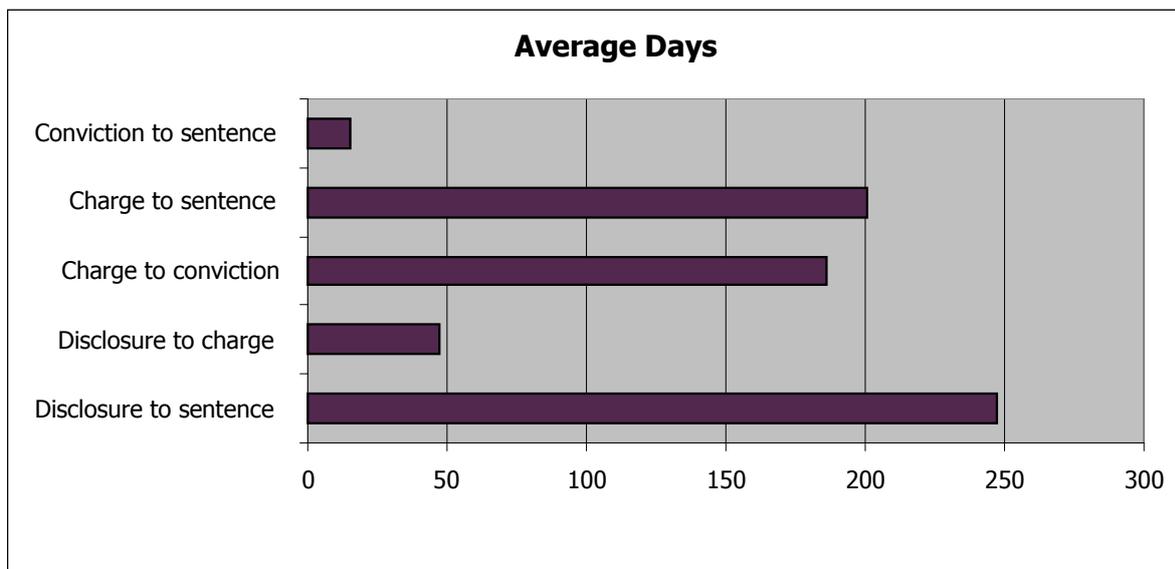
Disclosures

3.5 Responses following disclosure varied considerably both across areas and within areas. Strategy meetings, which brought together all of the agencies involved, were key in providing an opportunity to share information and agree a coordinated response. Unfortunately in many cases, strategy meetings were limited to discussions between the police and children’s social care services. Therefore, an early opportunity had been missed to share information between all relevant agencies in order to assess risks, needs and vulnerabilities based on all available sources of information. Most areas had arrangements in place to consider the needs of the child or young person and their victims separately.

Delays between disclosure and conviction

3.6 In every area inspected, there were unacceptable delays at almost every stage in the criminal justice process. Too often we saw an insufficient response when the risk of harm to others and the safeguarding needs of both the child or young person and their victims had not been sufficiently assessed or managed between disclosure and conviction. As a consequence little or no work was done with the children and young people or their victims to reduce the risk of further offending. By the time supervision had commenced, such a long time had elapsed since the offence that the children and young people were reluctant to discuss their sexual offending.

The chart below illustrates the average timescales in the cases we reviewed.



Initial assessment of risks and needs

3.7 The amount and quality of interventions following disclosure varied significantly and did not always sufficiently address safeguarding concerns in relation to either the perpetrator

or the victims. Initial assessments, where undertaken, were limited to the risk presented by the child or young person and rarely considered their potential vulnerability or explored the family circumstances to assess whether there may be ongoing risks to the child or young person or to other children and young people in the home. In almost all of the cases there were examples where either previous referrals for sexually harmful behaviour (ten cases) or the relevant past history of the family (21 cases) had not been analysed. Rarely did we see sufficient consideration of how and why the behaviour had occurred.

- 3.8 Lack of confidence to address these issues or understanding of the specific potential risk factors may well have been linked to insufficient specialist training received by social workers. We saw a better response in areas with staff with specialist training who responded to referrals, for example in Birmingham who had a specialist sexually harmful behaviour unit and in Cornwall & the Isles of Scilly where a specialist senior social worker dealt with all referrals.

Good practice example:

James was 17 years old when he was arrested for an offence of sexual assault. He was undertaking A-levels at college and hoped to go to university. Section 47⁶ enquiries were undertaken, an initial and core assessment completed on James and risk management plans were put into place as well as safe care plans for his brothers and sisters. In the very long time between the disclosures being made and conviction, James moved to live with relatives nearby. He was under considerable pressure and a children's social care services outreach worker was appointed to offer support. A local community organisation also paid for an independent counsellor. Throughout the period before conviction all workers recognised the impact upon James and were proactive in meeting his emotional and mental health needs as well as monitoring any ongoing risks. (**Cornwall & the Isles of Scilly**)

- 3.9 Generally, we found a lack of clarity about where these children and young people were located in the system, especially where sexually harmful behaviour was denied after disclosure. The child or young person was often seen as a perpetrator of a crime and few s.47 child protection enquires or formal child protection processes were invoked unless as a response to concerns about potential reprisals against the child or young person. Given that the majority of these children and young people had to contend with challenging personal, physical, emotional, family and home circumstances, it was surprising that often no further action resulted. Opportunities for early identification of concerns and appropriate intervention, which could have prevented the child or young person going on to commit sexual offences, were missed. The implementation of policies or procedures was rarely monitored proactively. Strategic managers were surprised to hear about the lack of inter-agency work at this stage and that multi-agency strategy meetings only occurred in a minority of cases.
- 3.10 While on this occasion, victims were not the focus of this inspection, we were particularly concerned that, although they were sometimes offered initial assessments, there were often unacceptable delays until the case came to court before action was taken. This was especially the case where the offences were being denied (see also 6.13).

⁶ Section 47 of the Children Act 1989 sets out duties for the local authority assisted by other statutory agencies to carry out enquiries in certain circumstances into whether or not a child or young person is at risk of significant harm and to decide whether they should take any action to safeguard or promote the welfare of a child or young person.

Difficulties of denial or refusal

- 3.11 Workers were unclear how to approach risk assessment or risk management where offences were being denied. This led to long periods when risks were not monitored or actively managed. The view that “*we can't do anything because it is only an allegation*” was prevalent, often arising from confusion amongst professionals between a finding or admission of guilt and the need to protect.
- 3.12 We found a lack of persistence to engage parents/carers, who came from all sections of the community, when they failed to cooperate. In these circumstances, social workers too often, on the basis of limited enquiries, were all too willing to decide the level of risk was low and close the case.

Darren lived with his mother and her partner both of whom worked in caring professions. Disclosures had been made about his behaviour towards younger females some months earlier, although it was some time before he was charged. He denied that he had committed the alleged offences and was fully supported in the denial by his family who refused to cooperate with an initial assessment. A very limited initial assessment was finally completed and a Child in Need plan developed but no Child in Need meetings took place. Information about his case was not shared across the agencies involved. Darren continued to attend college where some of the young women who had made the disclosures were also students. No work was undertaken with Darren, nor support offered, until he was convicted and sentenced some six months later.

Important role of schools

- 3.13 Schools, colleges and education, training and employment providers often had a very detailed knowledge of the child or young person. Following disclosure, we generally found a great willingness on the part of schools and education providers to work with other agencies to safely maintain children and young people in schools. We found good examples of education inclusion managers and schools working together to return or maintain the child or young person in education. In Tower Hamlets, we were impressed by the proactive and inclusive stance of the local authority to positive individual education development. This was reflected in the approach of the Pupil Referral Unit which was used as a stepping stone for pupils in the long-term plan to return them to mainstream education.
- 3.14 Given the level of information held by schools and their willingness to work with other agencies, we were disappointed to find that often they were not invited to initial meetings. This appeared to be based on a belief that schools would seek to exclude children and young people. Generally we encountered a reluctance to share information regarding the offences or risks with educational providers. The following comments are typical of those made by education providers:

Quotes from schools:

"We need to be functioning from the point of view of knowledge in order to be able to manage the case". Deputy Head Teacher

"School has tried to keep him within education but without a real appreciation of his behaviour and a lack of professional guidance about the risk he poses it has been difficult to properly risk assess and therefore complete the correct plans to manage the risk he presents". Safeguarding Lead Teacher

3.15 Nevertheless, we saw some excellent examples of risk assessments and risk management plans completed by schools who worked closely with the child or young person and their parents/carers. In Lancashire, the Children's Services Safeguarding Unit had put together a template for risk management plans and offered support to schools to develop appropriate risk management arrangements.

Good practice example:

Amir was 11 years old when information came to light that he and three other children and young people had sexually assaulted other pupils at his school. The disclosures were made in June 2010 and Amir was eventually sentenced to a youth rehabilitation order for 12 months in September 2011. The school worked with Amir and his parents, who strongly denied his involvement in the offences, to put in place a risk management plan to both protect Amir and other potential victims. The plan was comprehensive and dealt with all aspects of the school day, after school and holiday activities. It included an arrangement for the family to bring Amir to school, monitoring during breaks as well as library and computer sessions. The Assistant Head maintained contact with Amir and his family prior to sentence and the arrangements were closely monitored. It was evident that careful thought had been given about what information needed to be shared with staff in the school and the situation was handled sensitively. **(Tower Hamlets)**

Summary

- 3.16 There is little doubt that strong strategic coordination, which drives the response to children and young people who display sexually harmful behaviour, generally makes an effective multi-agency response more likely. At strategic level, there should be absolute clarity where these children and young people 'fit' between child welfare and the criminal justice system. We found that where the effectiveness of these arrangements is not reviewed gaps appeared between policy and practice.
- 3.17 Strategy discussions following disclosure, which take account of all the information from the various agencies, are critical in ensuring that safeguarding or child protection needs of the child or young person and their victims are adequately met and that appropriate action is taken to actively manage the risk of harm at an early stage. Schools and educational providers can provide detailed information which can help to inform decision making and they have a key role in assessing and managing risk following disclosure.
- 3.18 Initial assessments should be based on comprehensive information, take account of previous concerns, address the vulnerability of the child or young person as well as the risks to others and consider how and why the sexualised behaviour has happened. Where this had not taken place in response to previous concerns regarding sexualised behaviour, there were missed opportunities for early intervention which could have reduced the risk of future sexual offending. An improved multi-agency response between disclosure and conviction was evidenced where regular meetings were held between all relevant professionals to coordinate assessments, share information and review and monitor safeguarding or risk management arrangements.

4. Completion of assessments and developing plans

Key Themes

- Assessments were rarely shared between agencies and therefore we saw very few examples of holistic, multi-agency assessments being completed.
- Specialist assessments were undertaken prior to sentence in very few cases and pre-sentence reports were prepared in just over half the cases.
- The completion of specialist sexually harmful behaviour assessments were subject to lengthy delays during which time risk of harm to others was not being actively assessed or managed.
- Assessments generally lacked analysis of the underlying reasons or triggers for sexual offending.
- Information sharing and communication throughout assessment and planning was insufficient.
- The planning process required greater coordination across the respective agencies involved.
- There was often no clear link between key risk factors and intervention plan objectives.
- Young people and parents/carers were involved in assessment and planning and had been provided with clear information about roles and responsibilities of the agencies working with them.

Quality of assessments

- 4.1 Only a few assessments provided a comprehensive analysis of the sexually harmful offending behaviour in terms of triggers, risk factors, the level and nature of planning and whether there was a pattern of behaviour. As a result, we saw a number of cases where risk had been underestimated. YOT risk of serious harm analyses were assessed to be sufficient in 38% of cases. This was lower than the aggregated data from core case inspections of children and young people who had committed sexual offences where, based on a case sample of 48, 59% were assessed to be sufficient. As outlined previously, some workers struggled with how to address previous disclosures about a child or young person, which were often excluded from assessments on the basis that there had not been an admission of guilt.
- 4.2 It was unusual for social workers completing core assessments to include an analysis of sexually harmful behaviour; one commented "*We didn't consider it to be necessary to look deeply into the sexualised behaviour in our assessment- that was being handled by the YOT*". A significant proportion of initial and core assessments were based on limited information; some were superficial and lacked analysis of safeguarding needs or potential risks. As a consequence, needs were underestimated and minimal interventions were provided.

Holistic, coordinated, multi-agency assessments

- 4.3 Although we saw some good examples of holistic and coordinated assessments, it was rare to find that professionals routinely met to review, agree and share written assessments. Improvements were seen when the child or young person was being managed within a formal process such as child protection, MAPPA or Looked After Children. However, many children and young people were managed as 'Children In Need' which offered a less robust framework for coordinating and sharing assessments as review meetings to follow up on actions were somewhat variable. The effectiveness of YOT risk panels as a forum for sharing information depended on whether all the professionals directly involved with the child or young person were present. In some cases, as a result of poor communication and the lack of joint work, differences were recorded in the assessed level of risk of harm to others between agencies. Occasionally, despite a huge number of assessments completed, it was not clear why they had been undertaken or how they would be used.
- 4.4 In a number of areas, there was insufficient clarity about the relationship between YOT Risk Management Panels and MAPPA Level 2. The *MAPPA Guidance 2012: Version 4* states that 'A YOT cannot identify a case as requiring management at MAPPA level 2 or 3 and then decide that, because it is a multi-agency team, it does not have to make a referral to the MAPPA Co-ordinator'. Staff were confused about whether some cases met the threshold for management at Level 2. MAPPA was not always seen as being able to respond effectively to the needs of young registered sex offenders.

Specialist sexually harmful behaviour assessments

- 4.5 Specialist sexually harmful behaviour assessments were completed in 20 out of the 24 cases, with all but one being completed post-sentence. A pre-sentence report was prepared in just over half of the cases. There was more often a lack of a specialist assessment pre-sentence where offences were being denied. Most of these children and young people were sentenced without a full understanding of the sexually harmful offending or what needed to be addressed to reduce the risk of reoffending. The majority of areas used the AIM 2 assessment framework, a tool to assess sexually harmful behaviour and indicate the level of supervision required, and almost all staff reported that they had received appropriate training. It was not common practice for cognitive assessments to be undertaken prior to AIM 2 to establish whether this assessment framework was suitable, a concern given that 7 out of the 24 young people had an identified learning disability.

Good practice example:

In **Sheffield**, a cognitive assessment is undertaken prior to every AIM 2 assessment and a comprehensive report is provided by forensic CAMHS to the lead assessor. Professionals also have access to the Consultant Clinical Psychologist and the Forensic CAMHS team who offer a good level of advice and support in relation to work with children and young people who are involved with sexually harmful behaviour and sexual offending.

- 4.6 There was a varied set of arrangements for completion of AIM 2, across the areas inspected; the vast majority, however, had been completed by two workers who were mostly YOT staff. Although a number of areas had made a commitment to train managers in AIM 2, completed assessments were not regularly subject to any formalised or robust quality assurance process. Where completed, it was used solely as a scoring matrix with little analysis or interpretation of outcomes and it was rare for multi-agency meetings to be held following completion to agree a multi-disciplinary plan of intervention.

- 4.7 Timescales for completion of AIM 2 varied significantly with some taking up to four months to complete compared with the suggested 28 days. As most criminal court sentences are of a fixed term (i.e. a specific period of time, often months), delays in the allocation of a case to a worker, combined with the length of time taken to complete assessments, resulted in a number of cases where little time remained for any subsequent intervention. It was a concern that in a number of cases, risk of harm to others was not being actively assessed or managed pending the outcome of a specialist assessment.

William, aged 17, received a six month referral order for an offence of sexual assault against a girl under-13 years old, an offence he admitted when interviewed by the police. Although sentenced in October, due to difficulties with allocation and staff sickness, an AIM 2 assessment was not completed until seven months after sentence. William had no previous convictions or previous contact with children's social care services. His assessors did not check to see if he was known to the police and, after completion of the specialist assessment, were informed by the police about a previous incident when he had been charged with sending sexually explicit emails to a teacher.

- 4.8 We found significant gaps in information which led to inaccurate or incomplete assessments of risk of harm to others. On several occasions, police intelligence had not been sought or information from health had not been accessed. There appeared to be an over-reliance on previous knowledge and self-report from the child or young person. One worker commented that they had *"fallen into the trap of thinking I knew the young person when I should have explored more directly with other agencies"*.
- 4.9 The survey of 11 custodial establishments holding young people aged 15-18 years old undertaken by HMI Prisons identified that, in addition to the information received from the YOT, a referral would normally be made to the psychology department. In three establishments, the Lucy Faithfull Foundation (contracted by the YJB to provide an assessment and intervention service) undertook comprehensive assessments, whilst in another the National Society for the Prevention of Cruelty to Children (NSPCC) provided this service. Two of the four young men (who had been in custody) had specialist assessments completed whilst in there, one by the Lucy Faithfull Foundation and the other by the Barnardo's Taith Project. Both of these assessments had been shared with the relevant agencies.

Engagement of children and young people and parents/carers

- 4.10 It was encouraging to find that children and young people and their parents/carers had been involved in assessments and that they had been shared with them. Most of the children and young people and parents/carers we interviewed were very clear about the plan of intervention and the roles of the various workers. Their comments included;

Quotes from parents/carers and children and young people

"at the beginning I didn't like talking to people, but now I do because it helps you to get all your feelings out" Young person

"sometimes information is not shared – we need to know what is being done and how we can fit into that" Parent

"The purpose of multi agency meetings is to find out who is doing what...who we need to deal with." Parent

"They were checking on whether there was a risk to anyone else" Young person.

Role of police

4.11 The role of the police in the assessment of children and young people who had committed sexual offences was inconsistent. In a number of areas, the police had virtually no involvement, whereas in others, AIM 2 assessments and interventions were completed by seconded YOT police officers and we saw some good, coordinated joint work between police sex offender managers and other workers. We found little evidence of a clear and consistent strategic approach to the role of seconded police officers, some of whom received minimal supervision or direction about the core focus of their work. Gaps in police intelligence were more likely to happen where the YOT seconded police officer was not engaged in a structured way with the higher risk of harm work of the YOT.

Good practice example:

Dylan was a registered sex offender having been sentenced to a youth rehabilitation order for rape of a child under 13 years of age as well as sexual assault by penetration. During a visit, the police sex offender manager discovered that Dylan was due to start at a local college. This information was shared with the YOT seconded police officer and case manager who contacted the college who were unaware of the offences. Multi-agency risk management meetings were held and an excellent risk management plan was put into place by the school working with other agencies. **(Lancashire)**

4.12 Because there is no validated tool to assess the risk of harm by children and young people (in comparison to the assessment of adults who sexually offend where tools such as RM 2000 are available), the police have no structured way of assessing this risk. A greater level of sharing of risk assessments between YOT and police sex offender managers would enable increased consistency between the assessments of risk of harm to others.

Joint planning and quality of plans

4.13 Where children and young people were being managed through a formal child protection, Looked After Child or MAPPA process, joint planning, communication and information sharing was generally good. Otherwise, it was more ad hoc, lacking effective structures to facilitate sharing and agreement of plans.

4.14 Many of the children and young people had significant and complex needs and numerous plans had been developed by the relevant agencies involved. While it was more common for YOT and children's social care services plans to be shared, this was less evident with plans from other agencies, such as health. There were some notable exceptions, for example, in Tower Hamlets where plans developed by health were routinely shared. We found that information sharing by health workers was sometimes impeded by misunderstandings about data protection and confidentiality.

One health provider said:

"Services are not as coordinated as they should be... we are stuck in our organisational boundaries...we need to work together."

4.15 Whilst there were some good examples of integrated plans, especially risk management plans/child protection and school risk management plans, too often plans existed in isolation from each other, resulting in duplication or lack of coordination of the work.

4.16 YOT intervention plan objectives tended to be broad in nature, such as, '*work to address sexually harmful behaviour*' but did not specify exactly what work would be undertaken. Diversity needs were assessed and learning styles questionnaires completed, but plans did not always include how these would be addressed. We were concerned that a significant number of plans did not link directly to the outcomes of the AIM 2 assessment or to the type and nature of the sexual offending. Case managers lacked clarity about how to address sexually harmful behaviour in plans where the child or young person continued to deny the offences. The Good Lives Model approach, focusing on strengths, goals and aspirations, appeared to be an effective way to engage the child or young person in these cases. Although clearly evidenced as a key element of work to address sexual offending, it was disappointing to find that plans rarely included any family work other than references to family support.

Joshua, aged 16, was sentenced to a referral order for a sexual assault against an eight year old cousin. It was apparent that he had groomed the young girl by promising her that she could use his phone if she let him sexually abuse her. The assessment suggested that this was an isolated incident, despite the protracted nature of the offending, and the intervention plan consequently focused on helping him to develop a better understanding of consent issues. This did not appear to address the underlying factors which led to the offence.

Summary

4.17 Overall, there was little evidence of effective, joint multi-agency planning, which was based on integrated multi-agency assessments, to ensure all needs and risks were addressed and that each agency was clear about their roles and responsibilities. As a result we found that assessments were often inaccurate or incomplete and planning was not based upon a full picture of the child or young person's risks or needs. The significant delays in completion of specialist sexually harmful behaviour assessments led to a hiatus when there was little meaningful activity to assess or manage ongoing risks or to address the needs of the child or young person. It was particularly disappointing to find that specialist assessments tended to be completed in isolation, lacked interpretation and rarely formed the basis of a multi-disciplinary plan. There was clear evidence that where professionals met to share and agree assessments, the quality of assessment and planning was significantly improved.

5. Delivering interventions

Key Themes

- Arrangements for the coordination and review of interventions were frequently ineffective.
- There were some good examples of delivery of holistic interventions delivered by a range of agencies but these were not consistent.
- The majority of interventions to address sexually harmful behaviour were not delivered as identified in various plans and a 'pick and mix' approach was favoured which often did not link back to assessments.
- We found some good examples of interventions being delivered which were responsive to diverse needs, with clear commitment demonstrated to the child or young person by their families and a child centred approach.
- Gaps existed in information sharing and communication and the responses made following significant changes or to new information coming to light were often inadequate.
- MAPPA was not always used effectively and staff were unclear about the notification and referral procedures, thresholds and role of MAPPA.

- 5.1 The children and young people whose cases we examined during the course of the inspection had a number of different needs (see chapter 2) for which a wide range of interventions were required.
- 5.2 All of the cases in the inspection sample were male, ten of whom were under 16 years old and 19 were white British or European. Ten of the young people were identified as having a disability, in seven cases this was a learning disability. During the inspection other children and young people were identified as having a learning or communication issue which had not been previously recognised; this finding reinforced the importance of cognitive assessments being undertaken so that interventions were appropriately responsive to the child or young person's needs.
- 5.3 Although intervention plans did not always include reference to how the child or young person's needs were going to be met, all agencies appropriately addressed ethnicity, language and cultural issues as well as emotional or learning issues within their interventions with the children and young people and their families.

Good practice example:

Ewan had significant learning difficulties and his intervention plan on release needed to be very clear due to the number of agencies involved. The young person was very clear about the role of the disability social worker (*'stopping me from going home'*) who was making arrangements for accommodation and was supervising contact with his family and the YOT worker (*'stopping me from going back to prison'*). Both workers ensured they spoke to each other regularly and often undertook joint work. Ewan had a weekly diary so that he could keep track of all of his appointments. We saw excellent joint work between the social worker, YOT worker, Amelia Trust educational provision, the police, his foster carer and his immediate family. All of the workers ensured that the work they did was appropriate for Ewan and could be understood by him. **(Vale of Glamorgan)**

- 5.4 We reviewed a number of cases where all of the key workers had remained involved throughout a long period of intervention and had clearly developed strong working relationships with each other and with the young person. In these cases, a high level of communication and information sharing was clearly evidenced which resulted in excellent joint work, coordination of plans and delivery of interventions. Conversely, frequent changes of workers (one young person had seven social workers in six months) impacted on the effectiveness of communication and the quality of information sharing.

Range of interventions in response to complex needs

Health

- 5.5 Given the high proportion of children and young people in our case sample experiencing some form of difficulty with their health, we were surprised to find that the potential contribution by health practitioners to work to address sexually harmful behaviour by children and young people was frequently underestimated, both by the health services themselves as well as the other community agencies. In some areas, practitioners had taken part in AIM 2 training, others had to rely on their general experience and therapeutic background, Health involvement consequently varied significantly across the areas we visited as did their ability to take on this work.
- 5.6 A number of good interventions were delivered by CAMHS in one or two areas with strong strategic links and protocols in place to address referrals, access to treatment and confidentiality. In several areas, however, the referral routes into CAMHS lacked clarity. CAMHS eligibility criteria often precluded the acceptance of many children and young people with sexually harmful behaviour, despite the depth and complexity of psychological and emotional problems that underpinned their behaviour.
- 5.7 Mental health services were not always accessible for many 16-18 year olds in England and eligibility criteria restricted acceptance for treatment even when the young person was old enough to gain access.
- 5.8 Few referrals were found for Speech and Language Therapy services, even though communication difficulties have been found in a significant number of children and young people who sexually harm. The shortage of CAMHS trained nurses in YOTs limited the breadth of work they could carry out with these young men to address their complex emotional and psychological problems. In care and treatment plans, we saw an emphasis on assessment but relatively few examples of this leading to delivery of interventions either as a result of the lack of availability of required interventions or delays in accessing them. Even where particular interventions were recommended in psychology or psychiatric reports, these were rarely delivered. Responses to physical health needs were often a major gap although substance misuse services generally provided high quality interventions.

Education

- 5.9 Provision for education, training and employment interventions, where children and young people had not been maintained in school or educational provision was very mixed, ranging from consistently good work in some areas to a lack of engagement in others. We considered that access to appropriate education was a critical factor in reducing the risk of further sexual offending and where achieved, resulted in some positive outcomes, such as being able to maintain the child or young person safely in mainstream education and achieving recognised qualifications.

- 5.10 In Tower Hamlets, effective joint work between schools, the Pupil Referral Unit and the educational support service enabled two children and young people to be maintained in mainstream education and set goals which they were strongly motivated to achieve. In another area, a young person, aged 14, had been asked to leave school (not excluded) when the offences came to light as a result of the perceived risks he posed to other children and young people. This action is illegal, and despite a child protection plan in place, where minutes indicated that educational provision was a key action, the young person was out of education for over seven months. In authorities where there had been strong representation from education strategic managers, we generally found a more positive approach to maintaining these children and young people in education.
- 5.11 Several children and young people were very clear that help with their education and the attainment of formal accreditation was what they most valued about the help that was provided. This boosted their self-respect and enabled them to move into work.

Accommodation

- 5.12 We saw some very good examples of accommodation support, for example, by the Roundabout Project in Sheffield and Bedspace in the Vale of Glamorgan. Support workers played a key role in life skills work and provision of practical help to enable children and young people to maintain independent accommodation as well as an important role in monitoring their lifestyle and with whom the child or young person was associating. Generally, access to appropriate and supported accommodation was reported to be a problem especially for those under-18. As a result of new duties on local authorities resulting from the Southwark Judgment⁷, the numbers of Looked After Children had increased significantly and many areas were struggling to find appropriate placements.

Good practice example:

Simon was living in mainstream accommodation provided through the Roundabout project. He was supported by a team of staff who helped him develop independent living skills. When he 'failed' with his first tenancy because of the behaviour of visiting friends, they secured him another tenancy and worked with him to manage this. He was now doing very well and managing his own finances. **(Sheffield)**

Family support/family work

- 5.13 Direct work with families to address sexually harmful behaviour had been undertaken in very few cases. This was a surprise given the extensive research indicating the need to integrate families in sexually harmful behaviour work. However, we did see some very good examples, where excellent family support was provided. This work not only offered support during difficult times for families and showed what could be achieved, but also fulfilled an important monitoring role. The work seen during the inspection was culturally sensitive and responsive to the needs of the family.

Interventions to address sexually harmful behaviour

- 5.14 The majority of interventions were either cognitive behavioural or educational in approach. We saw some excellent interventions delivered by the Taith Project in the Vale of Glamorgan and G-MAP with a child or young person from Tower Hamlets. We also saw

⁷ **Southwark Judgment**

The Southwark Judgment, made by the Law Lords in May 2009, established case law that determined Children's Services could not deny entitlement to children if they fulfilled the criteria set out in the law and as such obliges children's services to provide accommodation and support to homeless 16 and 17 year olds whose family support networks have disintegrated.

effective use of The Good Lives Model, especially where the child or young person was in denial or minimising their sexually harmful behaviour. Interventions delivered by those with a specialist knowledge or role tended to be of a better quality. The majority of workers interviewed indicated that they had received sufficient training and felt confident to undertake the work, although one specialist worker had not received any training and suggested that it was possible to pick it up from manuals. This was interesting in the light of practice observed during the inspection which indicated there had been insufficient specialist training.

Good practice example:

The YOT case manager, working individually with one child or young person in our sample, delivered a comprehensive programme of interventions over 27 sessions which was based on a thorough assessment and addressed the sexually harmful behaviour displayed. The work, following training and consultancy from the Lucy Faithfull Foundation, addressed sexual behaviour, life skills, aggression, violence and conflict resolution. In addition, a community support worker worked with the child or young person to look at positive activities, keeping safe and appropriate relationships. Family support was also provided as a result of his mother's ill health in addition to a range of education, training and employment interventions. Upon completion of the work the case manager wrote a comprehensive report on progress and impact upon his risk. **(Plymouth)**

- 5.15 In a number of areas, staff opted for a piecemeal approach to the delivery of interventions and at times we had the impression that workers used a set of favoured exercises, regardless of whether they targeted the underlying risks or triggers or not. This may reflect either the quality of analysis and/or insufficient training. We saw many cases where the offence was being denied, where little or nothing in the way of structured interventions was delivered despite significant needs being identified.
- 5.16 Of the four custodial cases, two received specialist interventions during the custodial phase of their sentence one from Taith Project at the Hillside Unit and one provided by Lucy Faithfull Foundation in the Keppel Unit. The other two children and young people did not receive sexually harmful behaviour interventions as their sentence was too short to access the interventions provided in secure establishments.

Engaging the child or young person and their families

- 5.17 It was very clear that all of the professionals involved were child centred and demonstrated commitment to the child or young person and were successful in engaging them in the supervision process. As a consequence the need for enforcement action to be taken was required in very few cases, which is particularly impressive given that a large number of children and young people maintained their denial of the offence throughout supervision.

Good practice example:

Mark, aged 16, had a long history of offending and had failed to comply with many previous sentences. He was sentenced to 12 months detention and training order for indecent assault. He denied the offence and was convicted after trial. The worker from the sexually harmful behaviour team made contact with Mark's father and subsequently spoke to his keyworker in custody to ask him whether Mark would accept a phone call. He was then able to gain Mark's agreement to do some work based on the Good Lives model. Mark clearly gained much from the work because he increased his contact with the worker and planned to continue work after the community supervision element of his sentence had ended. We saw evidence of work on sexual knowledge and development, healthy relationships, issues of consent and the law. The work was reviewed regularly and the worker ensured Mark was fully involved in planning and goal setting. **(Birmingham)**

Almost without exception parents/carers were very positive about the work and were aware of the content of the intervention plan.

Good practice example:

The YOT case manager met with Nathan's family shortly after he had been sentenced to a 12 month referral order. The contract was discussed in full and involved completion of AIM 2, work on sex and relationships, a victim awareness programme, indirect reparation and direct reparation by way of a behavioural contract. The case manager explained who would be working with the family and offered them support. Throughout supervision, she continued to actively communicate with the family and provided them with regular updates on their son's progress as well as the potential impact on him. Nathan's parents were impressed with how the case manager had worked with them. **(Lancashire)**

Consultancy, supervision and oversight

- 5.18 We interviewed almost 100 staff from a range of agencies and whilst some said that they had sufficient specialist knowledge and training to work with adolescents engaged in sexually harmful behaviour, the majority indicated that they felt unskilled in this area of work. We felt this was particularly worrying for those workers who had frequent, often daily contact with the child or young person.
- 5.19 A similar pattern emerged in relation to access to appropriate professional supervision, especially for those staff undertaking therapeutic work. One police officer stated "*the supervision is as inconsistent as the practice*". Generally, specialist workers received good levels of supervision and oversight of the quality of the work by managers who were both knowledgeable and experienced in this field of work. Generic workers across the agencies, however, reported that whilst they received good quality supervision from their managers on a regular basis, it was less useful in relation to these specific cases. We observed a lack of 'challenge' by managers about the outcomes of assessment and the quality or appropriateness of interventions being delivered.
- 5.20 Some areas had provided specialist consultancy, which was highly valued by the staff as it provided the only means to gain specialist advice or guidance in relation to sexually harmful behaviour. In Sheffield, the consultant also provided regular training or development sessions, for example, working with children and young people who had been diagnosed with autism amongst other topics.

Coordination of multi-agency interventions

- 5.21 We found effective arrangements for the formal coordination and review of interventions in only a few areas. The lack of coordination occasionally led to duplication of work and confusion for the child or young person about who was delivering what. It was concerning that in some cases, the first time all of the professionals had met to review the case was at the meeting arranged as part of the inspection process. Too often we found that the level of coordination of interventions depended on the approach of individual workers and the quality of relationships they had established with colleagues from other agencies.

Good practice example:

Mohammed, aged 14, was convicted after trial for several sexual assaults against his younger sisters that had taken place since he was nine years old. Many professionals were involved with Mohammed and his family, who were described as difficult to engage. Mohammed was a Looked After Child, child protection procedures had been invoked in relation to his sisters and he was managed as part of multi-agency local risk assessment panel arrangement. Plans to work with the children and young people and/or their family had been prepared by the YOT, children's social care services and education. Communication between the respective workers was excellent: minutes of meetings showed that the plans were regularly being shared and interventions actively coordinated through Looked After Child reviews, core groups and the local arrangements for MAPPA. **(Birmingham)**

- 5.22 Structured meetings, such as the Multi-Agency Risk Management Meeting in Lancashire, provided the most effective means of coordinating and reviewing the effectiveness of the work. Some areas achieved this through a case planning forum, multi-agency risk meetings or professionals meetings. The level of coordination was significantly affected where these events did not take place.

Effectiveness of MAPPA

- 5.23 Of the 11 children and young people in the case sample who met the criteria for sex offender registration, four were subject to sexual offending prevention orders and a total of 15 were judged to have met the criteria for MAPPA. We found some confusion about which children and young people met the criteria for sex offender registration; this was understandable as the qualifying criteria are complicated for children and young people. MAPPA had not been used effectively in any of the six cases managed at Level 2, recording decisions and the follow up of actions being especially problematic.
- 5.24 We found that a lack of understanding of the role of MAPPA, thresholds and the scope of its responsibility. In some places, MAPPA was seen as a forum for agreeing disclosure whereas in others assumed decision making responsibility for the case, for example, refusing to allow a release on temporary licence to enable the child or young person to access education, training and employment provision. In two cases, we judged that the initial MAPPA level was too low. The specific risk and needs issues of young people who commit sexual offences are not necessarily understood within MAPPA, especially the difference between risk factors associated specifically with children and young people compared to adults.

Gaps in communication and information sharing

- 5.25 In this inspection, we were looking for regular meetings between the professionals involved with the child or young person so that *all* workers were fully aware of

information held by all the agencies and that appropriate action was taken where there was a change in circumstances or risk.

- 5.26 What we found was: where information exchange was linear, often with the YOT worker acting as a conduit, not all information was shared with all agencies, impacting upon the quality of risk management, safeguarding and child protection work. Where respective case workers worked together, we found good examples of the police offender managers holding the child or young person to account and this being reinforced by the YOT case manager. This had a positive effect on the child or young person and reminded them of their legal obligations.

Following his conviction, staff working with John learnt that he had established a relationship with a young woman aged 22, a similar age to his victim. The police sex offender manager had been told of his new relationship but no one seemed to know what action should be taken and by whom. No consideration was given to the safety of the young woman's children or whether John's conviction should be disclosed to her.

Summary

- 5.27 The most effective multi-agency work took place where professionals regularly met to review progress, update assessments and share information either through more formal structures such as child protection, Looked After Children or through case planning, risk management or professional meetings. It was disappointing to find that, because of the confusion about its role with young registered sex offenders, MAPPA was not as effective as it could have been with this group of children and young people.
- 5.28 Overall, the amount and the appropriateness and quality of interventions delivered specifically to address sexual offending were disappointing, especially where offences were denied. We found a lack of challenge or oversight by managers to check whether interventions were appropriate and of good quality. Work undertaken by specialist providers or those staff in a specialist role was generally of a much better quality and addressed the specific reasons underlying the offending. Similarly, where workers undertook joint work some positive outcomes were evident. It was disappointing to find that despite the evidence, little structured family work was undertaken regarding sexual offending and that, despite the high level of concerns, in the main health needs had not been met.

6. Achieving and Evaluating Outcomes

Key Themes

- The quality or effectiveness of multi-agency work with children and young people who displayed sexually harmful behaviour was not routinely evaluated.
- Very few areas had collated data and there was no specific routine monitoring of the impact of interventions with this cohort of children and young people or separate outcome measures.
- Appropriate responses to victims were variable – they were not always offered a service and where they were this often happened after there had been a conviction.
- Only one child or young person had been reconvicted for sexual reoffending.
- We saw evidence of progress regarding those factors relating to offending.
- Whilst there was evidence of an increase in protective and positive factors, this was not sufficient to safeguard children and young people.

- 6.1 We were very aware from our initial analysis of the sample for this inspection that this group of children and young people not only presented a significant risk of harm to others but also were themselves extremely vulnerable with a wide range of different needs, many of which had still to be addressed. Despite our concerns at the quality of much of the case management processes seen during the course of the inspection we were not therefore entirely surprised to find that once these children and young people were subject to direct, individual supervision by the YOTs, they responded positively to the additional attention and began to make progress.
- 6.2 Although overall the outcomes for this damaged group of children and young people improved, we were left with the worrying concerns that, if the quality of the case management processes had been better, interventions could have taken place earlier, more could have been achieved, or what had been achieved could have been more easily sustained.
- 6.3 Nevertheless, the key success of the YOT workers was to establish positive working relationships with the children and young people they supervised, so that they were able to address their needs as vulnerable adolescents while still focusing on the risks they presented to others. The children and young people in our sample clearly benefitted from the child-focused approach adopted by workers and their self-esteem improved. As a consequence, they became more receptive to change and engaged well with the supervision process.

When asked about their YOT workers, children and young people said:

"They try to make sure I enjoy it – not go home crying".

"He listened to me – he helped to put the good back in me".

Reducing reoffending and risk of harm

- 6.4 In relation to those children and young people who had previously offended, in our view, having examined the case records, the frequency of offending had been reduced in nine cases and the seriousness of the offending in three out of six cases. Whilst five children and young people (21%) had committed further offences, only one had been convicted of a further sexual offence (4%). This is below the sexual recidivism rates for children and young people, which falls between 5% and 14%. Whilst this is a small sample (24), and is not based on research methods, it suggests that despite some of the poor work earlier in the case, initial results look promising and work to investigate the success or otherwise of interventions is worthy of greater consideration.
- 6.5 The overall ASSET assessment score had reduced in 13 cases (one had not been completed for a Final Warning case and another had not had ASSET rescored) and in 14 cases some progress had been made against the most significant factors related to offending. The greatest progress had been made in education, training and employment (12); attitudes to offending (15); thinking and behaviour (13); and motivation to change (12) whereas there had been no progress for some young men on the following areas: family and relationships (17 out of 21); emotional and mental health (12 out of 19); and perception of self and others (14 out of 23).
- 6.6 Risk of harm to others had been effectively managed in only 1 out of the 22 relevant cases, largely as a result of insufficient assessments and plans and the ineffective use made of MAPPA. In 14 out of 18 cases, where relevant, risk had not been thoroughly reviewed following a significant change and in 10 out of 16 cases; changes in risk factors had not been anticipated wherever feasible or acted on appropriately.

Effective safeguarding and developing protective factors

- 6.7 Many of these children and young people had significant safeguarding needs which were not always responded to appropriately. Where risk factors had been identified in the ASSET assessment and then reviewed, those linked to safeguarding had reduced in 12 out of the 23 cases. In our view, safeguarding had been effectively managed in only 5 out of the 22 relevant cases, in that all reasonable action had been taken to keep to a minimum the risk of the child or young person coming to harm from themselves or from others.
- 6.8 In 16 cases, protective factors had been developed and some positive outcomes realised, especially in relation to education, with many children and young people being maintained in school or college and achieving well. Many of the children and young people had worked with a range of different projects linked to music, sports, creative arts and environment to engage them in pro social positive activities in order to reduce their isolation.

David was clearly pleased and proud that he had attained his goals: he had stayed out of trouble and had educational aspirations that he was on target to achieve. He also identified activities that he now undertook and enjoyed. His relationship with his parents had changed for the better and he was confident these improvements would be sustained.

Compliance

- 6.9 Three-quarters of the children and young people complied with the requirements of the sentence and sufficient action had been taken by the YOT in the majority of the small

number of cases where required. Despite the fact that a number of children and young people continued to deny the sexual offences following conviction, the majority engaged well with the worker. Enforcement action had to be taken in only three cases. Where the agencies worked closely together, the child or young person was not only encouraged to comply but was supported to do so.

An Intensive Supervision and Surveillance coordinator commented:

"When James started with us, he had lots of excuses for not keeping to his programme and it was important that he knew we checked everything out. This ensured he knew exactly where he stood with us and that we were working closely with all the other agencies that were involved with him. He began to accept the boundaries placed on him and develop some elements of self control".

Evaluation of outcomes

- 6.10 Outcomes of the multi-agency work with this group of young people did not appear to be *routinely* evaluated or reported to LSCBs, MAPPA Strategic Management Boards or YOT Management Boards who did not regularly evaluate whether policy had translated effectively into practice. Increased strategic oversight would have helped to address our concerns about the quality of the practice involved, in that it would have emphasised the importance of the work being jointly undertaken.
- 6.11 We did see evidence of audits commissioned by LSCBs but none focused specifically on children and young people who display sexually harmful behaviour. There were examples of reports presented to the LSCBs for a specific purpose but routine reporting of volumes, effectiveness and outcomes about this type of work was not expected by, nor provided to, strategic management groups. Therefore, service development was not based upon evaluation outcomes nor was the impact of existing provision monitored.
- 6.12 Whilst specialist sexually harmful behaviour service providers undertook systematic reviews of the effectiveness and impact of their interventions with individuals through reassessment or completion of psychometric or other measures, it was rare to see similar routine reviews of progress in relation to sexually harmful behaviour interventions undertaken by YOT staff and there was a tendency to rely on reoffending as a primary indicator of success. It was positive to see a number of cases where health workers had used the *Strength and Difficulties Questionnaire* to evaluate the impact of their work.

Victim work and focus

- 6.13 A significant issue to have emerged throughout this inspection was the inconsistent services provided to victims following disclosure. As a result of the lack of multi-agency strategy meetings and s.47 child protection enquires, full attention was not always given to their needs especially if they were unrelated to the perpetrator. We found social workers were not always sure how to respond especially when the offences were being denied. This led to long delays in any services being provided to victims. Responses varied from minimal contact by letter offering counselling services to very comprehensive assessments, support and management through formal child protection procedures.

In some cases, social work assessment of needs of (non-family) victims led to identification of other needs (unrelated to the crime) for which the victim/families received a Child in Need service. In other cases where allegations were denied it was not possible to assess or effectively protect children in the family until supported by the force of a conviction.

6.14 Following sentence, victims' safety did not always achieve the highest priority. YOT case managers had given sufficient attention to the assessment of the safety of victims in eight cases and a high priority was judged to have been given to victims' safety throughout the sentence in just seven of the cases. Victims' safety was often excluded from risk management plans. Overall, we considered the risk to victims had been effectively managed in just 3 out of 23 cases.

Summary

6.15 Only one child or young person had been convicted of a further sexual offence. The majority of children and young people had engaged well with the work and we saw high levels of compliance. This was often as a result of the child-focused approach adopted by workers and the commitment demonstrated to the child or young person.

6.16 There was some very encouraging evidence from the cases seen that the young men had made significant progress and positive factors had been developed. Many had attained qualifications, developed positive relationships, improved relationships with parents, obtained and sustained independent accommodation, learned strategies to manage anxiety and depression as well as developing conflict resolution skills.

6.17 Given what appeared to be some positive outcomes, we were surprised to see little evidence of any routine evaluation or monitoring at strategic level of the quality or effectiveness of the work with children and young people who sexually offend. Such oversight would have helped to address our concerns at the quality of the work undertaken. There was infrequent reporting and a view that exception reporting was the primary mechanism to highlight issues. As outlined earlier, given the potential harm this offending can inflict, we would expect to see greater strategic involvement in assessing the effectiveness of the work undertaken, particularly looking across the holistic multi-agency response and we have therefore made recommendations to this effect.

Appendix 1: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
ASSET	Structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
AIM 2	Assessment, Intervention and Moving on common assessment tool developed in Greater Manchester specifically for adolescents displaying sexually harmful behaviours
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
CSSIW	Care and Social Services Inspectorate Wales
DTO	Detention and training order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
HIW	Healthcare Inspectorate Wales
HMI Constabulary	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; constructive and restrictive interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A constructive intervention is where the primary purpose is to reduce likelihood of reoffending.</p> <p>A restrictive intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others.</p> <p>Example: with a sex offender, a constructive intervention might be to put them through an accredited sex offender programme; a restrictive intervention (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB. Both types of intervention are important</p>
ISS	Intensive Surveillance and Supervision: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
LAC	Looked After Child
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
NSPCC	National Society for the Prevention of Cruelty to Children

NCH	National Children's Home: the former name for the children's charitable agency Action for Children
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
PSR	Pre-sentence report: for a court
Risk of harm to others	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
The Good Lives Model of Offender Rehabilitation	A Strengths Based Approach – Tony Ward 2002 An approach providing attention to offender's internal values and life priorities and external factors such as resources and opportunities
YJB	Youth Justice Board for England and Wales

Appendix 2: 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*

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 our website:

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*

Care Quality Commission

Information on the Role of the Care Quality Commission 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*

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*

Healthcare Inspectorate Wales

Information on the Role of the Healthcare Inspectorate Wales and Code of Practice can be found on our website:

<http://www.hiw.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:

*Chief Executive, Healthcare Inspectorate Wales
Bevan House, Caerphilly Business Park, Van Road
Caerphilly, CF83 3ED*

HMI Constabulary

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

<http://www.hmic.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 Constabulary
6th Floor, Globe House, 89 Eccleston Square
London, SW1V 1PN*

HMI Prisons

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

<http://www.justice.gov.uk/about/hmi-prisons>

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*HM Chief Inspector of Prisons
First Floor, Ashley House, 2 Monck Street
London, SW1P 2BQ*

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Aviation House, 125 Kingsway
London, WC2B 6SE*

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