Introduction

271. Effective child protection is a fundamental part of safeguarding children and young people. Children's social care services have a statutory duty 'to safeguard and promote the welfare of children in their area who are in need and, so far as it is consistent with that duty, to promote the upbringing of such children by their families'.[85] They also have a duty to make enquiries if they have reason to suspect that a child in their area is suffering, or likely to suffer, significant harm. This is to enable them to decide whether they should take action to safeguard or promote the child's welfare. While different agencies such as social services and the police have distinct roles in child protection, all agencies who provide services to children and young people have a responsibility to respond to concerns where children or young people may be at risk of harm.

272. The report of the Victoria Climbié inquiry found that a range of agencies had failed in their duty to protect Victoria. There was a series of systemic failings that urgently needed to be addressed to avoid similar situations occurring in the future.[86] The first *Safeguarding children* (2002) report also found that attention to safeguarding in general and child protection in particular was in need of considerable improvement. These reports helped to inform the *Every Child Matters* Green Paper and the subsequent Children Act 2004, which established more robust systems for identifying and acting in partnership on welfare concerns.

273. The second *Safeguarding children* (2005) report noted that agencies were working together better and there was greater clarity about roles and responsibilities. However, there remained significant concerns about the ability of staff in some agencies to recognise the signs of abuse or neglect, the application of inappropriately high thresholds by certain social services departments in their child protection and family support work, and the capacity of local authorities to respond to all the children and families needing support.

274. Since 2005, the provisions of the Children Act 2004 have come fully into force. These include the integration of children's services, the establishment of LSCBs with guidance to focus on making their child protection work effective, and a new CAF to assist agencies in identifying welfare needs and revised arrangements for sharing information. The Government has also provided revised and updated guidance for agencies working with children. This chapter considers what has changed since 2005 and assesses how well these revised arrangements are working.

Compliance with *Working together to safeguard children*

275. *Working together to safeguard children 2006* (hereafter referred to as *Working together*) provides a national framework within which agencies work individually and together to safeguard and promote the welfare of children.[87] The Government revised the guidance in 2006 to take account of changes introduced by the Children Act 2004, particularly the establishment of LSCBs. The revised version also reflects changes to safeguarding practice in recent years, especially in the light of the Victoria Climbié and Bichard inquiries.[88,89]

276. JARs have found that nearly all areas have revised their child protection procedures in line with the new guidance. This includes strengthening procedures for the management of allegations against staff. Some LSCBs have collaborated to produce joint procedures to increase consistency in child protection work across local authority boundaries. However, in some areas, procedures lack sufficient practice guidance for staff. There are also gaps relating to particularly vulnerable children such as those with learning difficulties and/or disabilities and compliance with the Bichard recommendations.

277. JARs have also found that access to procedures and provision of guidance to staff are generally good across agencies. Most agencies have improved staff awareness of child protection responsibilities in nearly all areas. Designated members of staff are in place across most agencies. Schools have very good compliance in appointing designated child protection teachers. However, some areas report difficulties in recruiting designated doctors for child protection work.

278. Other inspection work reinforces the evidence about improved guidance and access. HM Inspectorate of Constabulary's programmed inspections of police forces in 2007 assessed the investigation of child abuse. In 2005 ACPO issued comprehensive national guidance on investigating child abuse and safeguarding children, compatible with *Working together*. Inspections found

that the *Working together* arrangements were well incorporated into force policies and procedures. Where inspections identified gaps, they related primarily to staffing and workload issues in individual forces or basic command units (BCUs). In particular, where cases were initially assessed as low risk, under-resourcing could lead to decisions about whether or not to carry out a criminal investigation being based on the availability of staff as opposed to established criteria. This resulted in such cases being passed to social care services for a single-agency response, with little or no active police involvement. Breakdowns in process in this area of work can, therefore, be underlying symptoms of resourcing difficulties. Few areas for improvement in staffing or process were identified in the best performing forces. In addition, these forces demonstrated the following common features: robust internal scrutiny arrangements, for example of the quality of investigations and compliance with criteria for investigations; the auditing of recording practices; and the active use of performance management information to drive improvement.

279. Despite the evidence of progress, inspections continue to raise concerns that some practitioners show less understanding of child protection and welfare needs than others. The second *Safeguarding children* (2005) report included evidence that not all NHS staff working with children knew how to recognise the signs of abuse or neglect. The Healthcare Commission's review of hospital services for children, published in 2007, showed that not all staff in NHS trusts had received basic child protection training.[90] There were particular shortfalls in training in services where staff should be trained to intermediate level, such as A&E and inpatient services. It is particularly important that staff in those services know how to recognise the signs and symptoms of abuse and can draw the attention of designated child protection staff to any signs of concern.

280. Cafcass plays an important role in safeguarding children's welfare in family court proceedings. This includes identifying children who might be at risk. Recent inspections of Cafcass regions have been highly critical of aspects of practice. Cafcass introduced an overarching child protection policy in 2004 and updated child protection procedures in 2007 as part of its Safeguarding Framework. Despite these initiatives, inspectors found considerable variation in front-line practice and raised serious concerns in the East Midlands region about inadequate practice, particularly in private law work. This included failure to make a referral to the local authority about identified child protection concerns. Similar findings were reported in Cafcass South East region and give grounds for concern that front-line child protection practice is not sufficiently robust.

281. Some CPS Areas have appointed specialists and champions for child abuse but their remit depends mainly on individual Area practice and those involved, as there is no central guidance for the role. The role of specialists and co-ordinators nationally is being reviewed in 2008. The CPS has established national networks to act as links between headquarters and CPS Areas for youth, rape and domestic violence related offences. However, there is no similar network for child abuse. There has been no national, overarching guidance for practitioners on child abuse, information having been until recently contained piecemeal within other procedural guidance. This situation resulted from the removal of out-of-date information and delay in introducing revised guidance. The gap has been partially filled by the recently issued safeguarding children guidance on victims and witnesses, which adopts the three key principles of expedition, sensitivity and fairness, although more comprehensive information on child abuse should be issued shortly. There is no central collation of information on child abuse cases; arrangements for the sharing of information between child abuse specialists and the analysis of casework are dependent on individual area practices and a policy-led practitioners group with restricted membership.

282. Inspectors found that child abuse cases were not allocated to CPS child abuse specialists in all cases. Nonetheless, child abuse cases were mostly satisfactorily handled. In 98% of cases the advice or initial review complied with the Code for Crown Prosecutors on both evidential and public interest grounds and in 96% of cases the charge reflected the seriousness of the offence. Shortcomings noted included inadequate guidance to prosecuting advocates with instructions, insufficient consideration of victims' views when discontinuing a case, and lack of proper handling of sensitive material. In addition, some files inspected had not been endorsed to show that the prosecution lawyer had reviewed child witness video evidence where it was available. The second *Safeguarding children* (2005) report also identified this as an area needing improvement.

283. In YOTs, children and young people dealt with often have a history of abuse or are judged as being at risk or

in need. Inspections found that compliance with child protection procedures was generally good or better. In spite of this, there were a small number of cases where child protection referrals should have been made but had not been adequately identified before the inspection itself. The YJB provides limited guidance on YOTs' statutory obligations and there is no 'best practice' guidance in relation to vulnerability and safeguarding.

284. The establishment of safeguarding managers in all youth offender institutions with YJB funding has helped to improve the management and overall understanding of child protection and wider safeguarding. It has resulted in a significant shift from practice that was mainly reactive and concentrated on child protection to a more proactive welfare approach based on a broader interpretation of safeguarding. Youth offender institutions, child protection policies are based on prescriptive guidance and a template issued by the HMPS as part of a Prison Service Order, which is compatible with *Working together*. However, some policies are little more than a reproduced template that has not been adapted to the local setting.[91] There is better attendance of local authority representatives at safeguarding committee meetings in prisons and some have worked with the youth offender institutions in the development of their child protection and safeguarding policies. Disclosure of historic abuse is common and generally well-managed, partly as a result of social workers now being established within youth offender institutions. They are well placed to liaise with child protection agencies from the young person's home area.

285. Despite these improvements, inspectors raised continuing concerns about areas of policy and practice within youth offender institutions. There is inconsistency about what constitutes a child protection referral and therefore the threshold for referral to the local authority. Very few referrals are considered to reach the threshold for a section 47 investigation. Most establishments refer allegations arising from the use of force to the local authority for investigation as a child protection concern. The threshold for investigation into what local authorities see as a legitimate procedure in a prison appears to be higher than in other settings where children make allegations about adults caring for them. Consequently, local social care services frequently make a recommendation that the youth offender institutions should carry out an internal investigation. Such investigations are frequently limited to the legitimacy of the procedure and inspectors came across examples where investigations had not been carried out as recommended. Guidelines to prisons about internal investigations are based on an adult Prison Service Order and consequently do not mention or include child protection considerations. New national procedures, whereby all allegations against adults who work with or care for children and young people are referred to local authority designated officers, are yet to be tested with regard to youth offender institutions.

286. Few youth offending institution policies contain detailed guidance on whistle-blowing that ensures that staff know they have a duty to report ill-treatment by other staff, how to do so and that they will be protected from reprisals. This is especially important within a closed institution. In addition, the quality of management information about child protection varies from excellent to very poor. Some establishments do not collect and analyse numbers and types of child protection referrals at all while others produce detailed trend analysis for the safeguarding committee. Safeguarding committees rarely have an oversight of reports of unexplained injuries. Injuries arising from the use of force are not consistently monitored for patterns or trends. With a few noteworthy exceptions, the use of force is not usually part of the safeguarding agenda but is instead regarded as a separate security issue.

Serious case reviews

287. An important part of the *Working together* guidance is the conduct of serious case reviews. Serious case reviews should be carried out when a child dies (including by suicide) and abuse or neglect are known or suspected to be a factor in the death. They can also be undertaken where the case raises particular welfare concerns. Examples include where a child has sustained a potentially life-threatening injury through abuse or neglect.

288. Where a case arises, the LSCB should establish a serious case review panel, involving at least the local authority children's service, health, education and the police. The panel decides whether the case should be the subject of a serious case review, applying criteria set down in *Working together*. Each service involved conducts an individual management review of its practices to identify any changes that should be made. The LSCB also

commissions an overview report from an independent person, which brings together and analyses the findings of the individual management reports and makes recommendations.

289. The responsibility for receiving notifications of serious incidents involving children and for evaluating the quality of serious case reviews transferred from the Commission for Social Care Inspection (CSCI) to Ofsted in April 2007. The DCSF, in partnership with Ofsted, has developed a new national child protection database for recording all notifications and information on serious case reviews. Local authorities are required to notify Ofsted of all incidents involving children that are serious enough that they may lead to a serious case review, including where a child has died or suffered significant harm as a result of abuse or neglect, or that raise concerns about professional practice, or that have attracted national media attention. Between 1 April 2007 and 31 March 2008, 281 serious incidents were recorded, which related to 189 deaths, 87 incidents of significant harm or injuries and five incidents where the outcome for the child was not known, for example where a child was reported to be missing following a serious incident. The spread of notified serious incidents across Government Office regions is set out in Figure 7. This shows a substantial variation which is attributable in the greater part to inconsistent reporting practices across local authorities.

Figure 7: Notifications of serious incidents by local authorities between 1 April 2007 and 31 March 2008

Government Office region	Death of child or young person	Serious incident involving child or young person	Other
North West	38	18	1
Yorkshire & The Humber	34	13	1
South East	28	9	2
North East	19	11	
London	21	9	
East	12	8	1
West Midlands	16	4	
South West	10	9	
East Midlands	11	6	
Total	**189**	**87**	**5**

Source: Ofsted.

290. The profile of the children and young people who are the subjects of the serious incidents is set out in Figure 8. Of particular note is the high proportion (41%) of babies under the age of one year who died or suffered significant injuries or harm.

Figure 8: Profile of children who were subjects of notifications of serious incidents between 1 April 2007 and 31 March 2008

	Percentage
Gender	
Male	44%
Female	56%
Age	
0–1 year	41%
1–3 years	13%
4–5 years	5%
6–9 years	8%
10–13 years	9%
14–17 years	22%
Unknown	2%

Source: Ofsted.

291. The Government Office regions provide guidance to LSCBs on carrying out serious case reviews. The DCSF has responsibility for publishing biennial reports on lessons emerging from serious case reviews, but has not yet published the report for 2005–07.[92] As part of its new responsibilities, Ofsted has introduced a more transparent and consistent process for evaluating serious case reviews. This assesses the extent to which the review fulfilled its purpose by reviewing the involvement of agencies, the rigour of analysis and the capacity for ensuring that the lessons identified are learned. The evaluation process aims to support the improvement of practice and safeguarding at a local and national level by ensuring that outcomes of all evaluations are notified to LSCBs, Directors of Children's Services and the DCSF. A report on the evaluations carried out since 1 April 2007 is scheduled to be published in July 2008.

292. The Prisons and Probation Ombudsman has responsibility for investigating the deaths of children in HMPS custody. Serious case reviews are also carried out in these circumstances. Although the Ombudsman and serious case review investigators make contact with each other, there is no guidance setting out how they should be coordinated.

293. There are considerable variations between LSCBs

in the number of serious case reviews they have carried out. Ofsted's survey of 118 LSCBs in 2007 showed that around a quarter had not carried out any at all compared with the 5% that had completed five or more (figure 9). While there are bound to be some variations, owing to the differing numbers of serious incidents and deaths of children and young people between local authority areas, they do not fully account for the extent of the discrepancy. It is also partly due to inconsistent interpretation by LSCBs of the guidance in *Working together*. Some LSCBs that had not carried out any serious case reviews had used alternative methods, including individual management reviews or case file audits. One area with no serious case reviews had four 'lessons learned' reviews in progress. Comments emerged from the survey about resource implications, potential media interest and the lack of a 'critical incident culture' in one area affecting the number of serious case reviews commissioned.

Figure 9: Frequency of serious case reviews (SCR) carried out by LSCBs between 1 April 2006 and 1 October 2007

Number of SCRs	% of LSCBs
0	24%
1	31%
2	24%
3	12%
4	4%
5	3%
6	1%
7	1%

Source: Ofsted survey of LSCBs 2007.

294. There are serious delays in the production of serious case reviews in most cases. They should normally be completed within four months of the decision to carry one out but nearly all take much longer. This is unavoidable where criminal cases are conducted simultaneously and there are associated *sub judice* issues. However, there is evidence that some of the delays are avoidable and the agencies involved have not given them sufficient priority.

295. The quality of serious case review reports varies considerably, including both overview and individual management reports. Since 1 April 2007, Ofsted has received 36 serious case reviews. Of those, 12 (33%) were judged good, 15 (42%) adequate and nine (25%) inadequate. The main characteristics of those that have been conducted well include:

- open and critical review of agency involvement
- clear analysis of actions
- well-constructed action plans to support lessons learned
- SMART[93] recommendations for future action.

296. Of those judged inadequate, significant weaknesses include:

- vague or over-general terms of reference
- failures to identify or address gaps in information
- lack of rigour in challenging shortcomings in practice
- insufficient focus on the child
- inadequate critical analysis of the involvement of partner agencies
- failure to secure the cooperation of partner agencies in three cases, including a mental health trust, another local authority and the coroner
- insufficient clarity about the lessons learned
- action plans unsupported by monitoring to ensure their implementation.

297. The results of Ofsted's evaluation of serious case reviews and the 2007 survey of LSCBs raise issues about the involvement and commitment of other agencies. Some services have issued guidance about involvement in serious case reviews, for example the CPS in its guidance on LSCBs and ACPO in its guidance on the investigation of child abuse cases and safeguarding children. However, there is evidence of a lack of priority given to serious case reviews by some local authorities and LSCBs have failed to secure cooperation from all relevant agencies in a few cases. Inspections of police forces also noted variability in the quality of individual management reports. In addition, the Healthcare Commission's audit of LSCBs raised doubts about whether trusts contributed effectively.[94] These related specifically to delays in producing individual management reviews and lack of monitoring of action plans.

298. Lessons learned from serious case reviews highlight the importance of sharing information and communication, accurate chronologies of events, clarity of planning and roles, overcoming the problems of hard to reach or potentially more resistant families, and the quality of assessment. Early recognition of children

in need of protection by mainstream services such as schools or health services is identified a frequent failure. Several also highlight difficulties in communication and the planning of intervention between adult or mental health services and core teams implementing child protection plans.

299. Several LSCBs have commissioned work to analyse and share the lessons from serious case reviews going back over a number of years (see examples below). In addition to contributing to two serious case reviews, the Healthcare Commission has worked with a former strategic health authority and the Commission for Social Care Inspection to review five serious case reviews where common themes emerged about professional practice relating to children in healthcare organisations.[95] These included shortcomings in the assessment of children's needs, failure to act on safeguarding concerns and poor communication between agencies and professionals.

Examples of LSCB work to share the lessons from serious case reviews

Croydon LSCB audited serious case review outcomes for the past four years to ensure that all actions had been carried through. It commissioned full executive summaries and has integrated the findings into training. The Corporate Parenting Panel has received summaries of serious case reviews to gain greater understanding of the issues.

Somerset LSCB completed a 10-year study of serious case reviews undertaken since 1995 and has identified domestic violence and parents with substance misuse problems as thematic issues for further work.

Schools in West Berkshire submit an annual report to their governing bodies (copied to the LSCB) on safeguarding.

300. Many LSCBs plan to make further changes to their serious case review arrangements to introduce greater rigour and objectivity. This includes the use of external or independent chairs of case review panels, the use of external expertise on individual management reviews and independent authors for overview reports.

Identification, assessment and management of children at risk or in need

301. The point at which concerns are first raised about a child is critical in achieving an appropriate response and a positive outcome. All those working with children should be able to identify children at risk of significant harm or those who are in need because of their vulnerability.[96] Despite the guidance available in this field, the second *Safeguarding children* (2005) report raised concerns that not all staff in all agencies providing services to children were equipped to do this. It also noted that most social services departments were applying inappropriately high thresholds and that lack of staff capacity meant that children and families in need might not be receiving the services they needed.

302. The numbers of referrals to children's services reduced between 2005 and 2007 but this masks significant variation between areas. JARs show that children's services in most areas have established clearer thresholds for accessing services since the second *Safeguarding children* (2005) report. This meets the requirement of *Working together* in paragraph 3.18, which requires LSCBs to clarify the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention. There is evidence of increased consistency in some areas in the application of thresholds in cases of neglect. This has resulted in earlier identification and increased registrations of children on the child protection register under the category of neglect.

303. However, in some areas thresholds for referring children to social care services remain high and a good understanding of thresholds across all agencies, while improving, is not yet fully established. This results in a lack of equitable access to services for children and young people in need. For example, some YOTs reported experiencing variable and frequently shifting thresholds for carrying out children in need assessments in social care, which they often described as resource-led.

304. JARs judged responses to referrals of child concerns to be safe and appropriate in nearly all areas. Arrangements in most local authority children's social care services for monitoring responses to referrals are robust. This has improved since the second *Safeguarding children* (2005) report. Front-line duty and assessment teams in children's services are generally well-managed

and links with health service staff are reinforced in many areas by placing a health visitor on each duty team. There has been an increase in the number of referrals leading to initial assessments, which indicates that clarity about thresholds is improving. Initial assessments are completed nationally within timescales in 68% of cases, and core assessments in 78% of cases, but both figures conceal considerable variation between authorities. The quality of assessments varies between outstanding and inadequate. Where there is good practice, assessments are timely; carried out in partnership with the child, family and relevant agencies; address holistic needs; provide a rigorous analysis of the available information; and properly consider the views of the child and parents or carer. Section 47 investigations into allegations of abuse or neglect are timely in most areas.[97] However, following interventions, some cases are closed without the necessary, or effective, communication with partner agencies.

305. There has been a slight increase in the numbers of children subject to a child protection plan (CPP), but re-registrations have not increased. The proportion of children subject to a CPP for more than two years has fallen slightly (figure 10).

Figure 10: Children subject to a CPP 2004–05 to 2006–07

	2004–05	2006–07
Number of children subject to a CPP	25,900	27,900
Child Protection Registrations per 10,000 population aged under 18	27.7	30.1
Numbers of children subject to a CPP per 10,000 population aged under 18	23.4	25.2
Re-registrations on the CPR per 10,000 population aged under 18	13.4	13.4
CPPs that were discontinued per 10,000 population aged under 18	28.1	28.8
Percentage of CPPs ceasing that had a duration of at least two years	6.0	5.8

Source: DCSF; the figures for numbers of children are rounded.

306. JARs have found that child protection plans are mostly of good quality and relevant and core groups that meet regularly support their implementation. Compliance with timescales for reviews of children subject to child protection plans has improved and nearly all take account of the views of children and parents. Independent chairing of reviews is helping to ensure the effective delivery of child protection plans. The allocation of child protection cases was nearly 100% in almost all areas, which is a considerable improvement on the findings of the second *Safeguarding children* (2005) report. There is generally good compliance with social worker visiting requirements, particularly for seeing children alone.

307. There is increasing provision of more effective earlier intervention services, which are targeted appropriately in areas of greater need. New and good services have also been developed to combat sexual exploitation. In addition, services to prevent family breakdown are reducing the numbers of looked after children. There has also been an increase in the allocation to social workers of children in need cases in some areas. However, preventive services are not well coordinated in some areas and access to these services is particularly difficult for children and young people and their families in rural areas.

308. Concerns remain about the identification and management of children and young people in the criminal justice system who might be at risk or in need. Young people who commit offences are often among the most vulnerable children in the community. YOT inspections found that 2% of children in YOTs and 3% of those in custody are on the CPR, which is higher than average. In the community 18% of children and young people who offend were assessed as a risk to themselves while 16% were at risk from others (family and peers). In custody these figures rise to 37% at risk of self-harm and 35% at risk from others.

309. YOTs have good child protection and safeguarding policies and procedures in place and there are many examples of effective inter-agency outcomes-focused work. However, policies are sometimes applied inconsistently. Home visiting only forms part of the assessment process in two thirds of all YOT and probation cases and there is a lack of consistent communication with parents and carers. Vulnerability plans do not exist in many cases and where they do, they do not always reflect the actual levels of vulnerability or the actions taken. Inspections revealed that one in five of all pre-sentence reports by YOTs were poor in assessing vulnerability and one in five probation cases were

insufficient in assessing safeguarding issues. In addition, 37% of probation risk assessments were insufficient in risk management planning for victim safety.

310. In terms of outcomes, YOT inspections judged that 82% of young people in the community who offend and who were assessed as at risk were the subjects of appropriate action. While this is commendable, it does mean that one in five assessed as at risk did not receive an adequate response. Of those at risk of harm in custody, inspections judged that 91% had received appropriate action from YOTs. When surveyed during YOT inspections, young people themselves showed less confidence in the interventions they had received.[98] Of those in the community, 14% had felt unsafe and 75% of those said they had received the help they needed to be safe. In custody, 16% had felt unsafe and 70% of those thought they had received appropriate help.

Example of appropriate action by a YOT

The YOT arranged pre- and post-custody Child in Need meetings for a vulnerable and violent young woman who was also pregnant. All relevant professionals attended the meeting and agreed a support package for her and her child. This included psychiatric treatment for her, education at a local PRU, attendance at mother and baby classes and childcare for her baby. Although her attendance at the mother and baby classes was not good, the YOT's parenting worker was involved in giving her support, her attendance at the PRU was said to be good and her behaviour had greatly improved.

311. Staff in youth offender institutions always complete initial vulnerability assessments for each new arrival but their quality is affected by the time of the young person's arrival and the extent of the information which accompanies them. Vulnerability assessments in youth offender institutions are generally not part of a process of continuous review and reassessment and care plans for managing vulnerability are seldom drawn up, even when risks are identified. There are good examples of effective systems to identify the most vulnerable young people and strategy meetings take place in some establishments to plan for the care of the most vulnerable. However, this practice is not consistent throughout youth offender institutions and caters for a small minority of the total youth offending institution population. Strategies for addressing different types of vulnerability rarely exist. Part of the remit of social workers in prisons is to promote the welfare of all children and young people held there and to complete children in need assessments where appropriate. Inspections have identified examples of improved service provision for young people following social worker assessments and the ongoing involvement of social workers in pre-release planning.

Common Assessment Framework and information-sharing

312. The Common Assessment Framework (CAF) for Children and Young People is a shared assessment tool for use across all children's services. It aims to assist the early identification of a child's additional needs and promote coordinated and integrated service provision.[99] It does not replace targeted assessment processes, such as those for children in need or with special educational needs, but is designed for use at an earlier stage before the threshold for multi-agency intervention is met. Directors of children's services, working with partner agencies, are responsible for implementing the arrangements in their area. Key features of CAF are:

- the designation of a lead professional who is responsible for coordinating the actions identified in the assessment process; he or she acts as the main point of contact for children where more than one practitioner is involved
- the effective sharing of relevant information between agencies and practitioners.

313. JARs found that most areas were on target to implement CAF and the Integrated Children's System, which is a case management and practice system for supporting children in need. Good training and project management have supported CAF's implementation. There is growing ownership of the lead professional role, especially in schools, and other agencies are increasingly involved in CAF arrangements, although their involvement still varies considerably. Many areas were less confident about implementing ContactPoint (formerly known as the Information-sharing Index), which will make basic information about all children and young people up to 18 in England available to authorised staff across agencies.

The main concerns of children consulted by the Children's Rights Director about the planned database were about the information held being incorrect or not held securely enough to prevent unauthorised access.[100] These concerns partly contributed to the Government's decision in June 2007 to postpone the implementation of ContactPoint pending a review of its security.

314. Acceptance of responsibility for completing assessments by staff in agencies other than social care varies considerably. Community health centres, schools and children's centres are making most progress. In some places there is also a perceived blurring of the distinctions between the assessment processes for children in need and those for children in need of protection. This has resulted in delays in recognising child protection issues. Also, assessment processes in other services, such as Asset in YOTs, which were developed separately, have not been updated to align with CAF.[101] The lack of alignment does not promote effective communication or information-sharing when assessing a child's eligibility for a range of targeted or specialist services. It is also a potential barrier to the effective operation of the Integrated Children's System.

315. Information-sharing between agencies is improving, although this is usually at operational level. Agencies such as the police and social services have well-established protocols and procedures for sharing information. For example, there is a model joint protocol produced by the CPS for the exchange of information between the police, CPS and local authorities during the prosecution of child abuse cases. Many criminal justice areas have adopted this or a local model, but some local authorities have declined to formalise arrangements.

316. Health information is less effectively shared, despite respect among health practitioners for the ethos of information-sharing between professionals. Inspectors also noted this in YOT inspections. This is partly because good practice in healthcare indicates that consent should be sought from a competent child or parent, which may sometimes conflict with safeguarding issues. The General Medical Council is reviewing its current general guidance on confidentiality.[102]

317. Forthcoming guidance from the YJB aims to improve the sharing of information about young people in the youth justice system and communication between relevant agencies and practitioners. The lack of initial information arriving with young people in youth offender institutions from YOTs remains a problem. However, social workers in prisons are producing some assessments of children in need and some are generating comprehensive data on safeguarding. The uncertainty of future funding for social worker posts in prisons puts this work at risk and may also stifle positive initiatives for information-sharing within youth offender institutions and with other agencies.

Management and accountability

318. The Victoria Climbié inquiry found that a lack of accountability for child protection among senior staff in most of the agencies that dealt with Victoria was a major factor in the failings that led to her death. Since then, the priority given to child protection has increased at senior levels in many agencies.

319. Structural changes to local authority children's services have helped to promote safeguarding and child protection across a wide range of services. Management oversight and supervision have improved in local authority children's services and front-line management is generally good. Front-line staff are better supported and have access to good quality supervision in most areas. Clear monitoring and case file auditing processes are in place, which is an improvement on the findings of the two previous *Safeguarding children* reports. This is leading to improvements in the consistency and quality of practice.

320. The implementation of workforce strategies in children's services has helped to reduce vacant posts and the numbers of social workers leaving posts overall. This masks variations in social work resources, which are limited in some areas, and the retention of skilled and experienced staff remains a problem. This results in lack of continuity for children and young people and delays in transferring cases between teams. There is also evidence that it has an impact on the application of referral thresholds in practice.

321. Management oversight and supervision vary considerably in other agencies. Many NHS trusts and PCTs have worked hard to raise the profile of children's services. Despite this, concerns remain about the priority given to children's issues by some NHS trust and PCT boards and independent healthcare providers.

Inspections of Cafcass have criticised the lack of clear accountability for and lack of supervision of front-line practice. In YOTs, there are clear systems of supervision and appraisal of staff and satisfactory spans of control but boards vary in their level of oversight of performance management. There is limited reporting of vulnerability and safeguarding issues to senior management.

322. HM Inspectorate of Constabulary's programmed inspections of police forces found clear links between performance and the effectiveness of accountability frameworks. All forces have identified leads at ACPO level with strategic responsibility for child protection and safeguarding children. The majority of forces operate under a devolved structure with operational and strategic accountability being split between BCUs (operational) and headquarters (strategic/policy). This means in practice that, while strategic and policy direction is maintained centrally, individual BCU Commanders have responsibility for taking decisions about how policy is implemented. Devolution therefore allows for the development of local solutions to tackle local problems. However, previous thematic inspections have identified that, when functions are devolved across BCUs, there is the potential for significant local variations and practices to develop. This can create difficulties for the strategic/policy lead in ensuring that policy is applied corporately across a force and that there is a consistent standard of response and service delivery. To address this, it is essential that forces have in place unambiguous accountability frameworks which clearly define the lines of operational and strategic responsibility at each level from practitioners through to chief officer lead. These need to be supported by effective performance monitoring, clear lines of communication and sound governance.

323. While all forces have accountability frameworks in place, they were not always effectively documented or communicated and some gaps in the chain of accountability were identified at senior management level, most notably at BCU Commander level. These areas for improvement were absent in the better performing police forces. These forces also demonstrated a number of key strengths which reinforce the links between good performance and effective accountability: the linking of accountability with performance management frameworks; effective governance and lines of communication; robust internal scrutiny arrangements (such as regular audit, review or 'health checks' to test compliance with policy and consistency in service delivery); and active monitoring of performance where areas for improvement have been identified. In line with the recommendation from the second *Safeguarding children* (2005) report, ACPO is developing a national performance indicator set for the investigation of child abuse.

324. All youth offender institutions have safeguarding committees to oversee the strategic management of all aspects of safeguarding but some committees lack clear terms of reference. Their size and structure vary considerably, as well as the level of child protection and safeguarding expertise of the membership. There are examples of excellent individual case monitoring of vulnerable young people and child protection referrals within a sound safeguarding committee structure. However, there are also examples of a lack of oversight of child protection by key managers in some establishments and an absence of clear accountability. Management lines vary and safeguarding managers do not always manage all staff with a safeguarding function. There is no system of supervision and support of individual front-line staff by managers within an accountability framework for staff in youth offender institutions. The responsibility of the LSCB for scrutiny of individual practice or overall monitoring has not yet been fully developed in this aspect.

Training

325. *Working together* states that all staff working with children should attend training in safeguarding and promoting the welfare of children. They should also receive regular refresher training. The second *Safeguarding children* (2005) report found that the frequency and quality of training vary considerably. This remains the case, although inspections noted improvements.

326. Much training is taking place that is directly relevant to safeguarding in general and child protection in particular. Many agencies have made a considerable investment in training. Examples include the following:

- JARs found good and well structured training strategies in most local authority areas. There is also multi-agency training covering wider safeguarding, as well as themed child protection practice.
- The CPS has made significant investments in training, including a rolling programme from 2005 to 2008 of domestic violence training developed with the

police for all lawyers and case workers, training for all lawyers and case workers on sexual offences, including a range of new offences such as grooming, and a training package in child abuse developed by a CPS Area, which will be rolled out nationally following piloting.

- ACPO has addressed the training gaps noted by inspections in the police service. Specialist investigators attend an initial crime investigators' development programme. More recently, a specialist child abuse investigation programme developed by the National Policing Improvement Agency has also been introduced.
- Training in YOTs is generally satisfactory or better, with good examples of inter-agency training. Training plans identify safeguarding and child protection training needs across the board for staff.

327. The HMPS has completed the roll-out of its national Juvenile Awareness Staff Programme (JASP), which includes modules on basic child protection awareness and safeguarding. Six out of 14 units inspected had 90% or more of staff trained, including the four smaller girls' units. However, only five out of 14 youth offender institutions had all staff trained, while three out of 14 had significant numbers of staff not trained at all. JASP is a generic programme covering a very broad base about how to work with adolescents in prison. It lacks the benefit of multi-disciplinary training. The programme has not been evaluated but the short modules covering child protection and safeguarding within it are unlikely fully to address the needs of staff in prisons working with some of the most difficult children in the criminal justice system. By contrast, training in secure training centres is more targeted and looks at issues such as autism and special needs.

328. Specialist training for safeguarding children with complex needs is generally good but it is often provided on a single rather than a multi-agency basis. There are some groups of staff that are rarely included in multi-agency training. For example, in some prisons, staff are able to take up offers of multi-agency training from the local authority. However, this is not the norm and some prisons have ceased to make joint training available to staff now that training is available through JASP.

329. There is sometimes an over-emphasis on training courses instead of in-house support for staff development, for example by seconded social workers in YOTs. Electronic learning and self-briefing can be effective learning methods, but this type of training needs to be followed up to determine its impact. Where training issues were identified for police forces, this was one of the commonest areas for improvement.

330. Access to training for certain groups of staff continues to be limited, as noted in the second *Safeguarding children* (2005) report. Reasons for this include workload and staff shortages. Some LSCBs also reported financing difficulties. These groups include staff in schools, youth services and children's homes, GPs, prison staff and some YOTs staff. The Healthcare Commission found that the absence of training for some staff was a significant area of risk for NHS trusts.[103] All trust staff should receive training in basic (level one) child protection training. Recognised good practice is for 95% of nurses in any one service to receive this training, but 58% of services (632) nationally did not achieve this. Nationally, low numbers of hospital specialists including surgeons and anaesthetists had received basic child protection training, although this varied considerably between trusts. Intermediate level (level two) training enables staff working with children to identify the signs of abuse. Good practice is for 95% of nurses in A&E and inpatient services to receive this training, and one nurse on each shift in day case and outpatients should be trained to level two. Only 70% of services (769) achieved this level of training.

331. Where training is well-planned and managed, there are common trends. For example, evidence from HM Inspectorate of Constabulary's programmed inspections in 2007 shows that the better police forces use succession planning to inform training needs, identify mandatory training needs for individual roles, incorporate learning from reviews and audits into training, and take up opportunities for joint training with partners.

Conclusions

332. Nearly all local authority areas have revised their **child protection procedures** in line with new guidance in *Working together*. Some LSCBs have produced joint procedures. Access to procedures and guidance to staff is generally good across agencies. There are still areas for improvement:

- Inspections continue to raise concerns that some practitioners do not have sufficient knowledge and understanding of child protection. They include staff in the NHS who have not received basic or intermediate child protection training, some front-line staff of Cafcass and a few instances in YOTs.
- Child protection in prisons has improved, but there are still areas of concern. These include the thresholds for external investigations and the rigour of internal investigations into allegations arising from the use of force. The recording and monitoring of child protection cases are very variable.
- In just under a third of cases, serious case reviews have been judged to be inadequate because of a lack of rigour in carrying them out. There are also serious delays in producing them in nearly all cases, some of which are avoidable. These factors limit the impact of serious case reviews on sharing the lessons and good practice arising from these cases and on improving practice.

333. Most local authorities have established clearer **thresholds** for access to children's social care services. Arrangements for the management oversight of front-line practice in children's services have also improved. Nearly all local authority child protection services are judged to be satisfactory or better. However:

- there is evidence that thresholds are still not well understood by referring agencies and thresholds are sometimes raised by local authority children's services in response to workload pressures, staffing shortages and limited resources
- the identification and management of children and young people in the criminal justice system who might be at risk or in need of additional support are less well-developed than in social care services; YOTs' pre-sentence reports were poor in assessing vulnerability in one in five cases inspected, while prisons do not assess vulnerability on a continuing basis
- lines of accountability and responsibility for child protection are not clear in all agencies, including some NHS trusts, Cafcass, YOTs, parts of the police service and youth offender institutions.

334. Most areas are making good progress in developing the CAF. **Information-sharing** between agencies on child protection or welfare concerns has improved at an operational level and there are well-established information-sharing protocols between many agencies. However:

- methods for assessing needs relating to safeguarding are not aligned with the national framework for assessment in all agencies; for example, the assessment framework used by YOTs, and the way it is applied, lacks rigour, as do assessment processes in Cafcass
- difficulties persist in parts of the NHS and throughout the youth justice system about sharing sensitive information on the needs of individual children and young people.

335. The provision of **child protection training** for staff across agencies is generally good and many agencies have made considerable investments in training. Despite this:

- some training, such as training for prison staff in juvenile awareness, does not cover child protection issues in sufficient depth
- access to child protection training for some groups of staff is limited; these groups include staff in schools, youth services and children's homes, GPs, prison staff, some YOTs' staff and nurses and hospital specialists.

Recommendations

Government and Local Safeguarding Children Boards

- The DCSF and LSCBs should ensure greater consistency in decision-making about when a serious case review should be commissioned.

Government and inspectorates

- Ofsted should report annually on the outcome of evaluations of serious case reviews.
- The DCSF should ensure that the national dissemination of biennial reports on the lessons learned is timely.

Government

- The DCSF and the YJB should ensure that the assessment tools used within the youth offending service and secure settings are robust in addressing the safeguarding needs of children and young people.
- The DCSF, the DH, the Home Office and the Ministry

of Justice should ensure that information-sharing arrangements between healthcare professionals and other professionals providing services for children are in place and monitored to ensure informed and coordinated service provision.

- The DCSF, supported by other relevant government departments, should provide an annual update of progress made on the recommendations in this report.

All agencies providing services to children and young people

- All agencies that have a statutory duty to cooperate on safeguarding children (local authority children's services, district councils, police, primary care trusts (PCT), NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should clarify the chain of accountability and responsibilities for child protection from the front line through to their most senior level.