HM Inspectorate of Probation

THEMATIC INSPECTION REPORT

'From Arrest to Sentence'

The Role of YOTs in the Safeguarding of Children

Home Office

2005

Foreword

Ensuring the safety and welfare of children and young people presents us all with a major continuing challenge. Despite our best efforts, we still hear of tragic cases of their mistreatment and even deaths at the hands of parents or carers, and the failure of the statutory agencies to offer them sufficient care and protection.

This report forms part of the second Joint Inspection, in keeping with the commitment by the Government that a review would be carried out every three years on safeguarding. It recognises the essential role of Youth Offending Teams and the importance of their work with colleagues across local authorities and the criminal justice system.

We were encouraged by many of our findings, and the progress made since the publication of the first Joint Inspection report in October 2002. It was apparent that Youth Offending Teams enjoyed a much higher profile on Area Child Protection Committees than previously, and were no longer as isolated. The teams themselves viewed their relationships with other agencies as a major strength in safeguarding children and young people, and one which could be further developed.

There is, however, no room for complacency and some areas still need to be addressed. As highlighted by the second Joint Inspection report, we identified the need for better monitoring of joint arrangements. We were also concerned by the lack of clear lines of accountability between different agencies in respect of certain activities, such as the containment of children and young people awaiting escort to secure institutions. And, at an operational level, Youth Offending Team staff need to give greater attention to the assessment of vulnerability, and ensuring that any apprehensions are communicated as required.

Our report contains a number of recommendations, to both the Youth Justice Board and Youth Offending Teams, which we hope will be helpful in taking the safeguarding agenda forward and maintaining the necessary focus on an issue which concerns us all.

ANDREW BRIDGES
HM Chief Inspector of Probation

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Acknowledgements

Numerous people, primarily YOT managers and staff, assisted with this inspection during the development phase. Rather than attempt to name them all and risk missing someone, we have listed the YOTs in which they worked, alongside the other individuals and agencies that were invaluable in setting up the inspection: Bolton YOT; Brighton & Hove YOT; Croydon YOT; Bedford Magistrates' Court; Jon Fayle, Peter Minchin, David Monk and Mary Geaney at the Youth Justice Board, Faye Deadman, Her Majesty's Inspectorate of Prisons; Rita Tucker, Her Majesty's Inspectorate of Constabulary.

We wish to put on record our gratitude to all of the above and to YOT managers, YOT staff, and members of other organisations in the five YOTs visited – Blackpool, Leeds, Oxfordshire, Suffolk and Wessex – all of whom participated in the inspection in such a constructive manner.

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June 2005

Glossary of abbreviations

AA	Appropriate Adult
ACPC	Area Child Protection Committee
ADHD	Attention Deficits Hyperactivity Disorder
Asset	Assessment tool developed by the Youth Justice Board
B&B	Bed and breakfast
BSS	Bail Supervision and Support
CAMHS	Child and Adolescent Mental Health Services
CPN	Community psychiatric nurse
CPS	Crown Prosecution Service
CRB	Criminal Records Bureau
CSCI	Commission of Social Care Inspection
DTO	Detention and Training Order
EDT	Emergency Duty Team
ESI	Effective Supervision Inspection
FREDAG	Fylde Race Quality and Diversity Action Group
HMCPSI	Her Majesty's Crown Prosecution Service Inspectorate
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMI Probation	Her Majesty's Inspectorate of Probation
HMIC	Her Majesty's Inspectorate of Constabulary
HMMCSI	Her Majesty's Magistrates' Courts Service Inspectorate
ISSP	Intensive Supervision and Surveillance Programme
LAA	Local Authority Accommodation
LAC	Looked After Children
LASU	Local Authority Secure Unit
NAAN	National Appropriate Adult Network
NPS	National Probation Service
Ofsted	Office for Standards in Education
OXYAP	Oxfordshire Young Abusers Project
PACE	Police and Criminal Evidence Act
PCR	Post-court Report
PSR	Pre-sentence report
SCS	Social Care Services
SLA	Service Level Agreement
SSD	Social Services Department
SSI	Social Services Inspectorate
YJB	Youth Justice Board
YOI	Young Offenders Institution
YOT	Youth Offending Team

1. KEY FINDINGS AND RECOMMENDATIONS

Key findings

1.1 **STANDARD 1: Management and partnership arrangements:** Senior staff in all YOTs expressed their commitment to safeguarding children and young people, although the extent to which this was evidenced in policy and procedures varied between YOTs. The vast majority had policies and procedures that were sensitive to safeguards issues. However, six YOTs reported having no safeguards related material at all and, more widely, disability and special needs were not being taking into account sufficiently. Monitoring was patchy and mainly confined, perhaps unsurprisingly, to those areas specified in YJB national standards. Nonetheless, we felt the fact that, as YOTs viewed their relationship with key partners as a strength, this was a good basis for the development of better joint monitoring. The YOTs' positive view of these partners was particularly encouraging, given the finding of the first *Safeguarding Children* report that YOTs were 'isolated'. Furthermore, YOTs reportedly had a much higher profile on ACPCs than in 2002. One important area for improvement concerned the 10% of YOT staff and volunteers who had still to be CRB checked.

1.2 **STANDARD 2: Work with children and young people in police custody:** The YJB needed to provide guidance to help YOTs adopt a more consistent approach to interviews with children and young people at the police station. Notwithstanding some excellent examples of child-friendly leaflets, YOTs were not doing enough to provide children and young people with sufficient and appropriate information about the justice system, and the service they could expect from the YOT. AAs, whether YOT staff or volunteers, were attending police stations promptly and were thought by both YOTs and the police to be offering an invaluable service. The AAs generally received comprehensive initial training, including child welfare and PACE, although ongoing training and support was less formalised. There was limited evidence that parent(s)/carer(s) were kept informed about the outcome of the interview. There were also issues of accountability regarding the management of children and young people following their appearance at a police station that required work from both YOTs and the police. The scarcity of local authority PACE beds was seemingly a large factor in children and young people being detained overnight in police cells. Whilst this was primarily an issue for local authorities, YOTs were not often seen to be engaged with housing agencies.

1.3 **STANDARD 3: Bail issues: Bail information and bail supervision and support:** Courts considered the service they received from YOTs to be 'excellent' and there was evidence of good practice amongst staff in a number of YOTs. However, there were some concerns around the extent to which YOTs took the safety and welfare of children and young people sufficiently into account in their delivery of services to the courts. Bail Assets were completed in less than half the cases inspected, with only a quarter of those assessed as being sensitive to safeguards issues. Despite this, these issues were addressed during interventions in the majority of cases. Examples of good partnership

working in support of children and young people were seen, and parent(s)/carer(s) were kept informed and involved throughout the period of bail.

1.4 **STANDARD 4: Pre-sentence reports:** Safeguards issues in general, and vulnerability in particular, were addressed in 80% of PSRs, a number of which were exemplary. Gender, religion and ethnicity were less well covered. It was not always clear whether children and young people understood what was in the report.

1.5 **STANDARD 5: Remands:** The arrangements between the YOT and their social services partners needed to be clarified to promote better working relations between front line staff. The required paperwork for children and young people remanded to the care of the local authority was not always completed by the YOT when it was its responsibility to do so. In respect of secure remands, it was encouraging that YOT staff were following guidelines when requesting a place for children and young people in secure accommodation and some good practice was seen, with YOT staff working hard to make secure facilities staff aware of particular vulnerability issues. However, we also found some worrying cases where young people had been remanded to prison custody and had remained there until sentence, with no evidence of any input from the YOT. Finally, there was some confusion and concern expressed by YOTs around which agency was responsible for a child's or young person's welfare whilst awaiting escort following a remand.

Recommendations

The YJB should:

1. *Support YOTs in discharging their responsibilities by advising them on their strategic role on Local Safeguarding Children Boards and provide further direction on work to safeguard children and young people.*
2. *Clarify the wording of standard 2.8 in the National Standards for Youth Justice around notifying parent(s)/carer(s) following their child's or young person's interview with the police.*
3. *Clarify accountability for children and young people awaiting escort, having been remanded to secure facilities or custody, and provide guidance to YOTs accordingly.*

YOT managers should:

4. *Ensure that they are in the forefront of planning with partners for Local Safeguarding Children Boards.*
5. *Ensure that Bail Assets are completed at the child's or young person's first appearance at court.*
6. *Improve the quality of recording of bail work in both electronic and paper case files.*
7. *Explore options for contributing to planning and review meetings in secure establishments where distance makes YOT staff attendance difficult, e.g. video conferencing.*

8. *Ensure that induction, training and supervision for both staff and volunteers addresses safeguards issues, including training to recognise signs of abuse or neglect.*

9. *Provide training to staff to help them to identify and promote safeguards issues in secure establishments, i.e. planning and review meetings.*

YOT managers, in working with children and young people in police custody, should:

10. *Review the effectiveness of any existing protocol between the YOT, police, AA provider and EDT (where relevant), with particular reference to:*
    - *daily 'coverage' of interviews with children and young people at the police station*
    - *attendance at interviews when there is no solicitor present*
    - *procedures around releasing children and young people in paper suits*
    - *accountability for getting children and young people home safely from the police station*
    - *arrangements for keeping parent(s)/carer(s) informed of the outcome of the police interview.*

11. *Ensure that there is a mechanism for AAs to feedback to the YOT any concerns they had about children and young people.*

12. *Improve recording of AAs' input at the police station, with particular regard to checks made on the welfare of children and young people.*

YOT managers, in working with partner organisations, should:

13. *Establish or improve arrangements to monitor performance in relation to safeguards issues in conjunction with key partners such as the police and social services.*

14. *Set up and maintain a process whereby all staff and volunteers who are involved with children and young people are CRB cleared at 'enhanced' level and have this clearance reviewed every three years.*

15. *Liaise with key partners, particularly SCS, to establish a common language around and understanding of thresholds for intervention with children and young people.*

16. *With social services, clarify agency roles and responsibilities when a child or young person is remanded to the care of the local authority.*

2. AIMS, OBJECTIVES AND CONTEXT OF THE INSPECTION

Background

2.1 In October 2002 the first joint report on arrangements to safeguard children and young people was published. This joint report was commissioned by the Chief Inspectors of eight regulatory bodies following a commitment by the Government that a review should be carried out every three years on how well children are being safeguarded. The second and subsequent joint report is due to be published in July 2005.

2.2 This, separate, report focuses on the contribution made by YOTs to the safeguarding of children and young people between arrest and sentence. Nonetheless, the report's findings will contribute to the second joint safeguarding report.

2.3 For the purposes of this report, we used the definition of safeguarding used in both the 2002 and the 2005 reviews:

- *all agencies working with children, young people and their families take all reasonable measures to ensure that the risk of harm to children's and young people's welfare are minimised; and*
- *where there are concerns about children's and young people's welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies.*

2.4 A steering group led by CSCI (then SSI) was set up to oversee the process of inspecting arrangements to safeguard children and young people. It included representatives from HMIC, HMI Prisons, Ofsted, the Health Commission, HMMCSI, HMCPSI and HMI Probation. The overall aim was:

to review the arrangements across agencies to safeguard children, giving particular attention to children's views and experiences, progress since the last report and the areas identified within the first review as requiring more attention. The review will result in a report to the Government making recommendations as necessary.

2.5 The steering group agreed the following themes for the review:

- Children living at home
- Children living away from home
- Children in the judicial system
- Children seeking asylum.

2.6 The methodology for the review included:

- revision of existing inspection activity and collation of relevant findings
- adjustment of existing inspection activity to gather evidence
- new inspection activity to address gaps in information

- where possible to seek the views of children
- analysis of research and statistics.

2.7 HMI Probation was to focus, along with HMCPSI, HMMCSI and HMIC, on children in the judicial system and in criminal court proceedings. This was to be achieved through an inspection of the YOTs' contribution to the safeguarding of children and young people between arrest and sentence.

2.8 In addition, HM Chief Inspector of Probation pledged to inspect the work of the NPS in relation to child protection through a review of existing inspection activity and collation of relevant findings. The aim of the NPS element of the inspection was to gauge, albeit indirectly, how well probation areas contributed to child protection. This assessment would be made by comparing the management of child protection cases (of which 53.9% were adjudged to be 'high' or 'very high risk') against the management of other 'high risk' offenders, using existing data collected during the first 14 ESIs.

Aims and objectives of the YOT inspection

2.9 In March 2004, HM Chief Inspector of Probation contacted five YOTs: Oxfordshire, Leeds, Suffolk, Blackpool and Wessex, and invited them to participate as one of the fieldwork sites for the Safeguarding inspection. He also wrote to the respective Chief Executives of the local authorities to inform them of the proposed inspection and its purpose.

AIM:

To assess the extent to which YOTs contribute to the safeguarding of children and young people in the judicial process from arrest to sentence/disposal.

OBJECTIVES:

- *To determine whether YOTs have taken into account sufficiently the safety and welfare of children and young people in their arrangements with and delivery of services to the youth court.*
- *To assess whether children and young people are provided with sufficient and appropriate information about the court process in which they are involved.*
- *To establish the extent to which the YOT promotes and respects the rights of children and young people throughout the judicial process between arrest and sentence.*
- *To determine how effectively children and young people are safeguarded during the court process by the YOT working in cooperation with all those agencies taking part.*

2.10 The inspection activity was to focus on the following provision of services as part of court proceedings:

- AA services
- bail information

- bail support
- PSRs
- remands.

Inspection standards and criteria

2.11 The current inspection standards and criteria were taken from the original seven standards and criteria, which were circulated to YOTs in April 2004. The original document was designed to cover the main areas of service provision listed in 2.10. The current version has seen the seven standards condensed into five main headings (see Appendix 2).

The inspection process

2.12 The YOT inspection was divided into two 'phases' that ran concurrently. The first phase consisted of two days of fieldwork in each of the five YOTs visited. These five YOTs are referred to in the report as the 'inspected YOTs'.

2.13 The five YOTs themselves were chosen for two main reasons: i) they had already shown an interest in being part of the ongoing 'core' joint YOT inspection process which commenced in September 2003, and ii) their size, location and throughput of children and young people made them of particular interest in terms of how they addressed safeguard 'obstacles' thrown up by their individual demographic profile. For example, Leeds YOT served one of the busiest youth courts in England, whereas the Isle of Wight team had possibly one of the smallest. Blackpool YOT catered to a seasonal population likely to include the children of migrant workers or young students on exchanges. Two YOTs, Oxfordshire and Suffolk, were inspected at the same time as they were undergoing a full inspection from the YOT Joint Inspection team. The two inspection schedules, whilst run independently, were designed to create the minimum disruption to the YOTs.

2.14 The methodology of the first phase required the inspected YOTs to submit information in advance of the inspection, including a position statement specific to safeguarding. Day one of the fieldwork was the inspection of files chosen on the basis of an HMI Probation formula, although YOTs nominated the individual files themselves. The file read process sought to gather information to inform Standards 2 to 5, and the results of the file read formed the basis for these sections of the report.

2.15 In total across the inspected YOTs, 40 remand files were read on site. In addition, a total of 30 AA checklists or PACE forms and 38 PSRs were read off site in the days following each inspection. The data collated and analysed from this material are referred to as 'the file read'.

2.16 Day two of the fieldwork consisted of interviews between the inspector and several managers and operational staff, including the YOT Head of Service.

2.17 The second phase involved a questionnaire on safeguarding issues (see Appendix 3) being sent out to all 138 YOTs in England. Of these, 93 (67%) were returned before the deadline, and a number of YOTs also submitted good practice materials such as copies of protocols and training plans. The data collated and analysed from these returned questionnaires are referred to as 'the audit response'.

2.18 The questionnaire's content mainly focused on Standard 1: Management and Partnership Arrangements, although several questions did include some aspects of other standards and criteria. YOT managers completed the majority of questionnaires with the assistance of deputies and/or operational managers, and the results were therefore based on their perspectives. No senior members of the steering group or other partner agencies were interviewed as part of the inspection.

2.19 The inspected YOTs were also required to complete a separate questionnaire. This was an extended version of the one sent out to all the YOTs, the main difference being that more questions were dedicated to the other standards, although the focus remained on Standard 1.

2.20 Finally, we also reviewed data collected from children and young people who completed an interactive CD ROM-based questionnaire, administered in several YOTs during Phase One of the Joint Inspection. (YOT staff often administered this themselves with children and young people with whom they were working: the sample cannot therefore be considered random or necessarily representative of all children and young people in YOTs.) Although the questionnaire asked about experiences post-sentence, we were able to focus on the responses to questions that had a link with safeguarding issues, with a view to assessing how well these children and young people felt that their interests and expectations were being taken into account by the YOTs. The findings are discussed in Appendix 1a.

2.21 In the review of the data from the first 14 ESIs, we found 113 child protection cases in which the offender had been identified by the inspector as the main source of risk to the child or young person. The inspection scores on these 113 cases were then compared to 163 cases that had been identified by the inspector as 'high risk', but did not involve any child protection issues.

2.22 It was hypothesised that, if the NPS was contributing to good child protection across the 14 probation areas through effective case management, then the scores for the 113 child protection cases would be at least as strong as the scores for the 163 non-child protection high-risk cases. The findings are discussed in Appendix 1b.

3. STANDARD 1: Management and partnership arrangements

Description of STANDARD 1.1: Partnerships

There is a shared understanding, evidenced in policy and practice, between the YOT, its statutory partners and other organisations including the ACPC, about how children and young people will be safeguarded and protected.

3.1 **The key findings of STANDARD 1.1 are:**

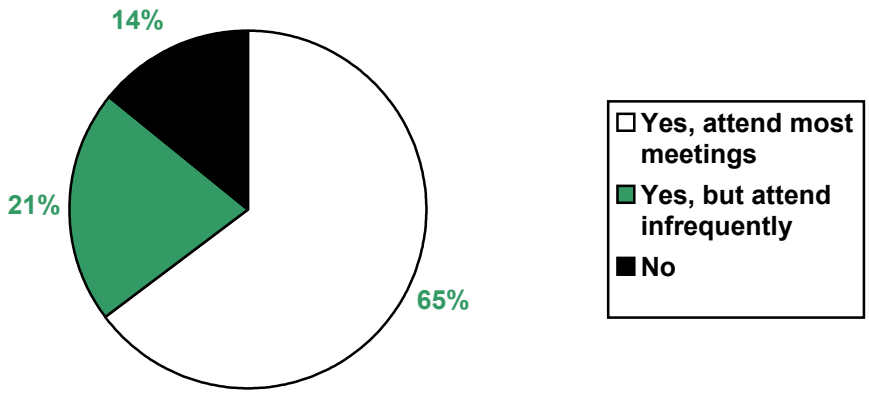
- high membership and improving involvement of YOTs in ACPCs
- liaison on safeguarding issues between YOTs and their partners generally described as strong
- the majority of YOTs had complaint procedures for children and young people
- only 42% of YOTs had information sharing protocols that addressed safeguarding issues.

Criterion: ***Information relevant to the safeguarding of children and young people is shared appropriately between agencies.***

3.2 The first main finding of the 2002 *Safeguarding Children* report was that YOTs were not often represented on ACPCs and consequently, a recommendation was made that guidance be immediately issued to ensure that, "local Youth Offending Teams ..... are invited to become full members of all ACPCs".

3.3 We looked to see whether that advice had been followed: the number of YOTs that were full members of ACPCs are shown in Figure 1 below.

Figure 1: YOT membership of the ACPC



Commentary

- It was positive that 86% of YOTs were full members of the ACPC. Several YOTs reported that, though they were not full members at the time of responding to the questionnaire, they had recently been invited to join.
- A number of YOTs were still not full members or had fallen into abeyance.
- Worryingly, one YOT stated that they had asked to become members of the ACPC but that their request had not been accepted. One inference to make from this situation is that statutory services were still failing to recognise the important role that YOTs were able to play in safeguarding children and young people.
- Furthermore, there was some confusion about the position of YOTs in relation to the forthcoming 'Local Safeguarding Children Boards'; a number of managers suggested that YOTs did not have a 'seat' on the board, when in fact they were to be statutory members. YOTs clearly needed to be made fully aware of their responsibilities in respect of Local Safeguarding Children Boards.

Good practice example:

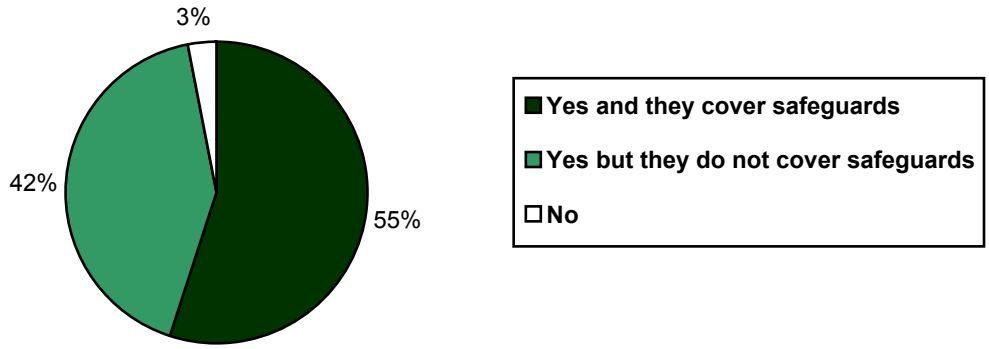
There were some examples of good representation that had led to close working relationships. In Bolton and Cumbria YOTs, for instance, the operational managers were members of the Divisional Child Protection Subcommittees or equivalent.

3.4 The position with regards to ACPC membership amongst the YOTs inspected was promising. Blackpool had recently joined the ACPC and the YOT manager felt that this change represented a commitment on behalf of the ACPC to 'move forward' on child protection work. Leeds was to attend from July 2004. Suffolk had what the inspectors felt to be a good structure, whereby the Head of Service attended the full ACPC and the designated locality manager attended the Policy, Procedures and Planning Subcommittees, whilst Oxfordshire and Wessex were members but attended infrequently.

Criterion: ***Protocols between agencies include agreed standards for practice that address the tension between data protection concerns and the sharing of information on risk.***

3.5 We asked the YOTs if they had any information sharing protocols with other agencies involved in youth justice. The response is shown in Figure 2 below.

Figure 2: Proportion of YOTs who have information sharing protocols with other agencies involved in youth justice



Commentary

- The majority of YOTs reported having information sharing protocols, but these did not cover safeguards.
- The fact that 55% of YOTs did not attach sufficient importance to sharing information on safeguarding issues, such as child protection, was of considerable concern.

Good practice example:

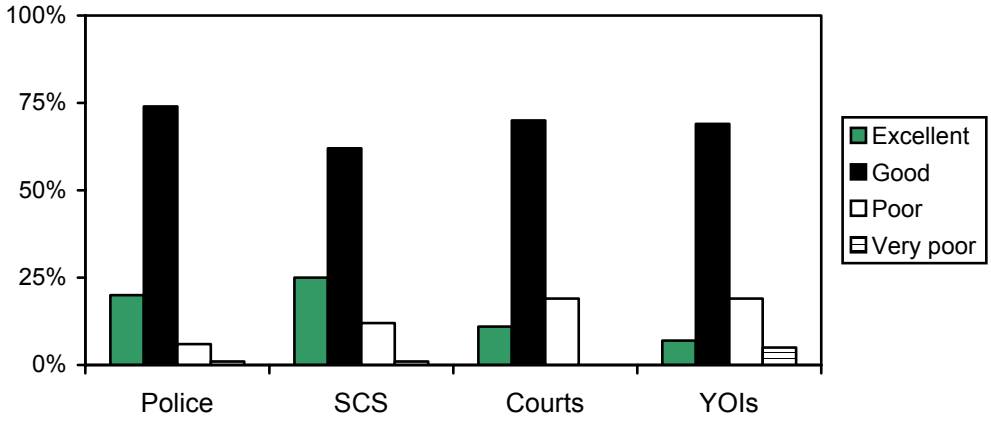
Of the YOTs who felt that they did sufficiently cover safeguards, Greenwich supplied a draft protocol for the YOT and its partner agencies that incorporated relevant legislation, details of the information to be shared and a 'request form' for sensitive information.

3.6 Of the five YOTs inspected, three had information sharing protocols that adequately addressed safeguards issues. Oxfordshire's included how and when children and young people and their parent(s)/carer(s) should be informed about their rights to access information held on them (pre-sentence).

3.7 Three of the five YOTs had established a mechanism by which AAs could feedback to the YOT any child protection or welfare concerns that they had picked up during their time at the police station.

3.8 The 2002 *Safeguarding Children* report also commented on the 'relative isolation' of YOTs from other services. We explored this issue and asked the YOTs for their views on the quality of liaison with their primary partners. The results are shown in Figure 3 below. (YOTs were also asked about four other agencies, but those shown below were thought to be the ones with whom YOTs worked most closely between a child's or young person's arrest and sentence.)

Figure 3: How the YOTs rate the quality of liaison on safeguarding issues with the police, SCS, the courts and YOIs



Commentary

- Overall, YOTs described the quality of liaison on safeguarding issues with their main partners in positive terms. This was encouraging, particularly given the finding from the first *Safeguarding Children* report.
- We felt that the ratings given to SCS by the YOTs were especially pleasing, in that the many interfaces between YOTs and SCS were often around the emotive issue of children's and young people's accommodation. Despite the frustrations experienced by YOT staff in dealing with what they felt to be a service under pressure, the feelings they expressed about SCS were often ones of understanding and sympathy.
- From the graph it can be seen that, although ratings are very similar for each service, the overall level of what could be termed 'satisfactory liaison' (the combined total of liaison rated as 'excellent' or 'good) falls, reading left to right across the chart, from the police to YOIs.

Quality of liaison between YOTs and their primary partners

Police: The main interface between YOTs and the Police was the work of AAs (see Standard 2). The majority of custody sergeants interviewed were positive about the YOT/AA service. However, the Isle of Wight police described feeling frustrated with the service during the recent period of transition from one AA provider to another.

From AA coordinators' points of view, the assessment tended to be more equivocal, and less positive than the figures from the audit suggest. Suffolk described problems around access to legal advice: Suffolk Constabulary did not see children and young people as vulnerable in the same way as they did vulnerable adults. Consequently, AAs were not permitted to overrule children and young people whom they thought were not in a position to make an informed choice about legal representation (see Standard 2.4). The YOT manager reported that he was awaiting guidance from the YJB on this issue.

It could be that the high ratings given for police/YOT liaison in the audit were partly a product of the questionnaires being scored by YOT managers, as opposed to AA coordinators; the latter likely to have a better 'working knowledge' of the relationship and its flaws.

SCS: Links with SCS were not rated the highest of the four key agencies. It was still, however, an encouraging figure, given the importance of the link with SCS around remands to local authority and the critical comments contained in the original *Safeguarding Children* report over their thresholds for services. Oxfordshire had recently drawn up a new YOT/SCS protocol that went into detail on remands to LAA and it was hoped that this would clarify responsibilities around LAC paperwork, an issue that appeared to be contentious for a number of YOTs and SSDs. Similarly, the SLA between Wessex YOT and SCS required regular liaison meetings between the respective Heads of Service in order to deal with the issue of roles and responsibilities.

Courts: The five YOTs inspected generally reported their links with the courts to be 'good', and that senior managers regularly attended Youth Court User Groups or the equivalent. Without exception, the courts felt that they received an excellent service from the YOTs. One senior court representative interviewed said that the YOT was the one agency that could be relied upon to have comprehensive information about the child or young person in court. Another stated that, "Compared to other criminal justice agencies in this area, the YOT comes top of the tree by quite some distance", a sentiment echoed by other court staff in the different areas covered.

YOIs: YOTs gave the highest numbers of 'poor' and 'very poor' ratings to liaison links with YOIs. This figure reflected some of the comments made by YOTs in both the national audit and the fieldwork about the problems faced in ensuring children and young people remanded to YOIs were safeguarded.

It is likely that those YOTs situated near to a YOI, or even to have members of the YOT permanently based in the YOI, as in Suffolk, were in a better position to develop joint training initiatives.

Good practice example: Audit

YOTs described different means by which they had sought to address problems with YOIs, with joint training initiatives featuring strongly in the examples given. Wigan reported how over 260 prison operational staff had been trained in child protection procedures by a social work qualified YOT officer. Bournemouth said that they had been involved in similar training and had extended it to include police officers. Barnsley supplied a protocol entitled 'Child Protection Procedures for Barnsley Based Professionals Working with Young People in Wetherby YOI', which had been agreed by the Governor of HMYOI Wetherby, the Area Manager (Juveniles) and the Senior Child Protection Coordinator for Leeds SCS. Their intention was that this protocol served as a template for other secure establishments and SCS.

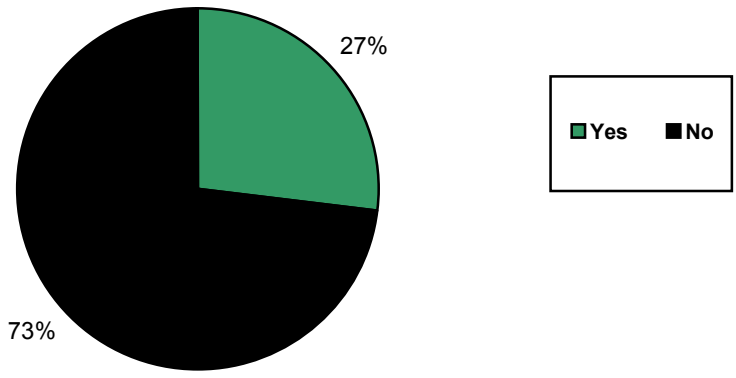
Good practice example: Inspected YOTs

Members of the Leeds YOT management team attended a number of operational meetings with partners. One such meeting was a bi-monthly with representatives from Leeds SSD, in which issues such as intensive fostering and the impact of the Children's Review were discussed and joint initiatives made. The B&B protocol between the YOT, SSD and the court was proposed in this forum.

Criterion: ***Local policies that clarify cross-boundary arrangements with neighbouring YOTs outline clearly how children and young people will be safeguarded and protected.***

3.9 The response to the audit question linked to this criterion is shown in Figure 4 below.

Figure 4: The proportion of YOTs whose policy cover cross-boundary issues with neighbouring YOTs



Commentary

- Of those YOTs nationally who replied that they had cross-boundary policy, only a couple supplied any relevant information or examples, mainly in the shape of regionally agreed policy between several (neighbouring) YOTs.

3.10 None of the YOTs inspected had specific policy on this issue, but commented that ACPC guidelines applied.

3.11 Despite the apparent lack of clearly communicated policy, some of the cross-boundary cases picked up in the file read were well managed. However, these were usually cases where the child's or young person's 'home' YOT was in the same area, or adjacent county. Even in the absence of regionally agreed policy, it was likely that YOTs within the same county or region would have a greater awareness of a neighbouring area's local authority arrangements, than one at the opposite end of the country. Consequently, cross-boundary policy would still be of benefit to help children and young people from further afield.

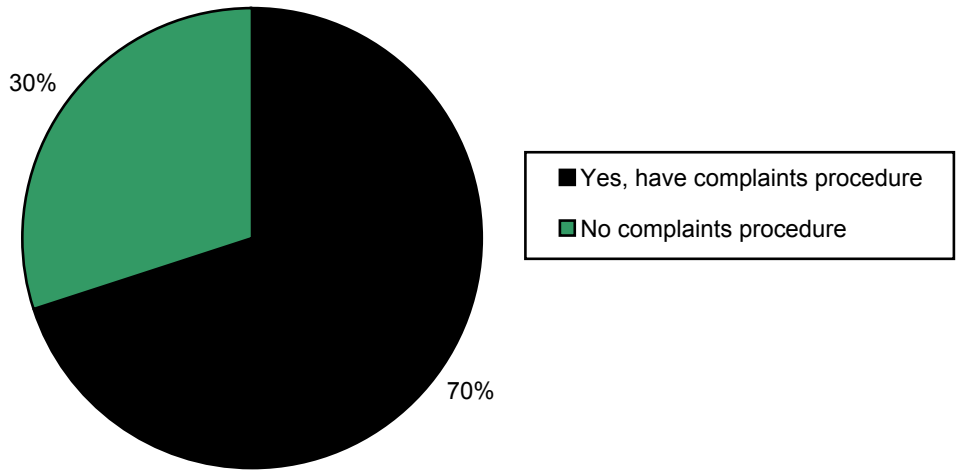
Good practice example:

Possibly due to their isolation, the Isle of Wight team seemed to be well practiced in dealing proactively with children and young people from the mainland arrested on the island. A YOT officer managed to trace an asylum seeker's social worker, which had proved difficult due to the young person's name being spelt differently on the SCS's system, and helped establish a meeting in Feltham YOI.

Criterion: ***Protocols between agencies promote the respect of children's and young people's rights and include effective complaints processes and access to advocacy for both children and young people and their parent(s)/carer(s).***

3.12 The responses to the audit question linked to this criterion are shown in Figure 5 below.

Figure 5: The proportion of YOTs who have a complaints procedure for children and young people in the judicial process



Commentary

- It was positive that over two-thirds of YOTs said that they had a complaints procedure that was accessible by children and young people *between arrest and sentence,* as opposed to only post-sentence. All but one of the YOTs who provided additional details clarified that its procedure covered all children and young people coming into contact with the YOT, rather than having a separate set of procedures for pre- and post-sentence.

3.13 A similar picture emerged from the YOTs inspected. In Suffolk, Leeds and Oxfordshire, the procedures were outlined on leaflets, often on the reverse side of information for children and young people. Any complaint made would generally be investigated using the local authority's procedures.

3.14 There was little evidence that sufficient attention had been paid to how parent(s)/carer(s) would be made aware of their rights to complain and what they might expect from the YOTs. This was disappointing, particularly as YOT staff interviewed consistently expressed their commitment to involving parent(s)/carer(s). Knowing what they might expect from the YOT and having the facility to complain if they felt they had not received the 'advertised' service would help parent(s)/carer(s) feel that their experience was considered important by the YOT.

Description of STANDARD 1.2: Leadership

The management board communicates the importance of safeguarding children and young people through its strategic oversight of, and direction provided to, the YOT

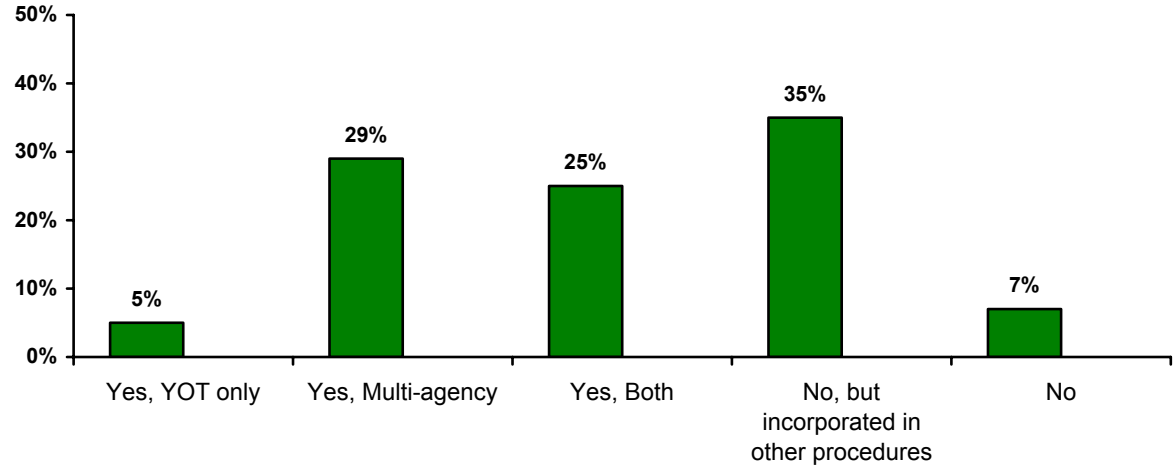
3.15 **The key findings of STANDARD 1.2 are:**

- nearly two-thirds of audited YOTs reported having specific policy, strategy and procedures addressing their role in safeguarding children and young people
- only 55% of YOTs had policy and procedures that addressed diversity; only 53% had policy and procedures that addressed disability or special needs.

Criterion: ***The management board gives guidance and support to the YOT manager, ensuring that they have clear policies, strategies and procedures to ensure the safeguarding of children and young people.***

3.16 The YOTs' responses to the audit question linked to this criterion are shown in Figure 6 below.

Figure 6: Proportion of YOTs who have specific policy, strategy and procedures addressing their role in safeguarding children



Commentary

- It was promising that 59% of YOTs had specific policies addressing safeguarding issues, either covering the YOT only, the YOT and partner agencies, or both.
- Only 7% of YOTs described having no safeguard related policy or procedures; this nonetheless represented six YOTs whose staff were presumably working without such guidance.

3.17 Some YOTs described working particularly closely with ACPCs to increase the policy's relevance to children and young people involved with the YOT: Norfolk reported having had a lead role in the writing of their county's procedures. Other YOTs outlined regionally agreed procedures, which they felt assisted in reaching a shared understanding of safeguarding issues. Stoke-on-Trent stated that all their contracts had a 'Safeguards clause' to ensure commissioned services adhered to local ACPC procedures.

3.18 The largest category of respondents, however, was the 34% of YOTs who reported that they did not have specific policies, strategies and procedures, but that information pertaining to the safeguarding of children and young people was incorporated in other procedures. Whether or not this was a satisfactory state of affairs, in terms of the importance the YOTs appeared to attach to safeguarding, depended on how clearly these other procedures referenced safeguarding issues and how well they had been communicated to staff. In some unsatisfactory cases, phrases such as 'being aware of' and 'taking into account' were not explained and it was not clear how staff should proceed in order to comply. In other YOTs, such as Oxfordshire, a number of good quality documents were supplied which demonstrated how safeguarding issues could be addressed within information exchange or risk management documentation.

3.19 Interestingly, when asked to suggest improvements at a local or national level, the response most often made by YOTs was to request National Guidelines from the YJB on good practice in relation to safeguarding issues, or a forum whereby good practice

could be shared and discussed. We, of course, acknowledge that the YJB has a role in promoting a consistent response to safeguarding issues, but would encourage YOTs to take forward these issues at a local level. The evidence from this inspection proves that YOTs are able to develop promising regional protocols, and effective initiatives at this level could then inform a national debate around safeguarding issues.

Good practice example:

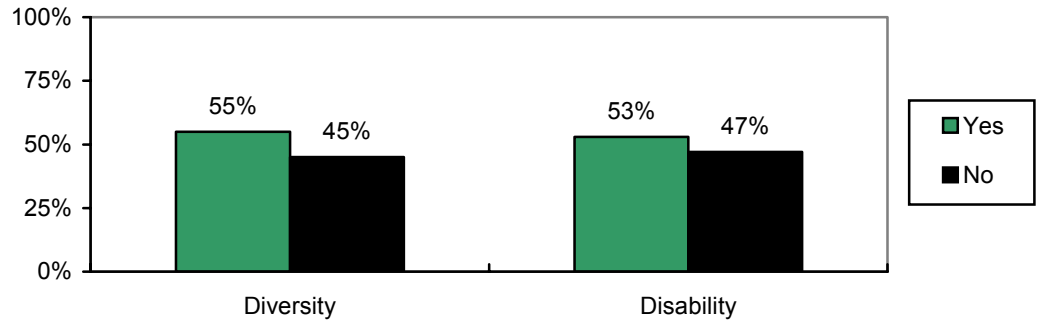
In the immediate aftermath of the Climbie enquiry, Wessex Management Board produced a guide for managers that identified the key implications of the enquiry for the YOT.

Criteria: ***Policies, procedures and practice take full account of, and are appropriate to, the needs of children and young people with a disability or special needs.***

Policies, procedures and practice take full account of, and are appropriate to, a child's or young person's unique ethnic and wider diversity needs.

3.20 The audit response to the questions linked to these criteria are shown in Figure 7 below.

Figure 7: The proportion of YOTs whose policies and procedures cover a) race, ethnicity and wider diversity issues and, b) disability and special needs



Commentary

- It was disappointing that only 55% of YOTs reported that their policies and procedures took account of, and were appropriate to, the wider diversity needs of children and young people in their areas. Those that did claim to have such policies included Barnsley YOT, who stated that their regional (South Yorkshire) child protection policy contained specific sections on black and minority ethnic young people, racism and racial harassment, and gender issues.
- Although 53% of the YOTs reported that they had policies and procedures that covered disability and special needs, few submitted examples of their policies and procedures. None of the YOTs inspected addressed this issue in policy. It is an area clearly that requires development.

3.21 None of the five YOTs inspected had specific policies covering diversity; (most using their local authority's race equality policy) disability or special needs. Leeds had a policy that addressed diversity issues in relation to staffing but not operational matters.

3.22 We felt that the accurate recording and monitoring of ethnicity and wider diversity needs in the YOTs inspected could be greatly improved by better PACE monitoring forms. A good example of such a form was found on the Isle of Wight where Home Office ethnicity categories were being used. These forms also had space to record if the child or young person had wider needs such as health and language. However, improving the forms was not sufficient in itself to ensure that diversity information was accurately recorded: any such initiative would also need to be supported and maintained by good training.

3.23 Local authority guidance was thought to be too general to address the provision of ethnically appropriate services and placements. Similarly, issues regarding ethnic isolation were not often addressed and in one area were not seen as a priority.

3.24 There was some evidence, however, that the YOTs retained a focus on diversity. Blackpool was a member of the FREDAG established by Lancashire Magistrates' Court. It was hoped by the YOT that FREDAG would lead to improvements in identifying and responding to ethnicity and diversity issues within the remand system.

Good practice example:

Oxfordshire had a diversity group that met regularly and the deputy YOT manager had recently written a research paper on diversity issues to provide a frame of reference for the group, who were tasked with developing policy.

Description of STANDARD 1.3: Monitoring

A focus on safeguarding results in measurable improvement in outcomes for children and young people.

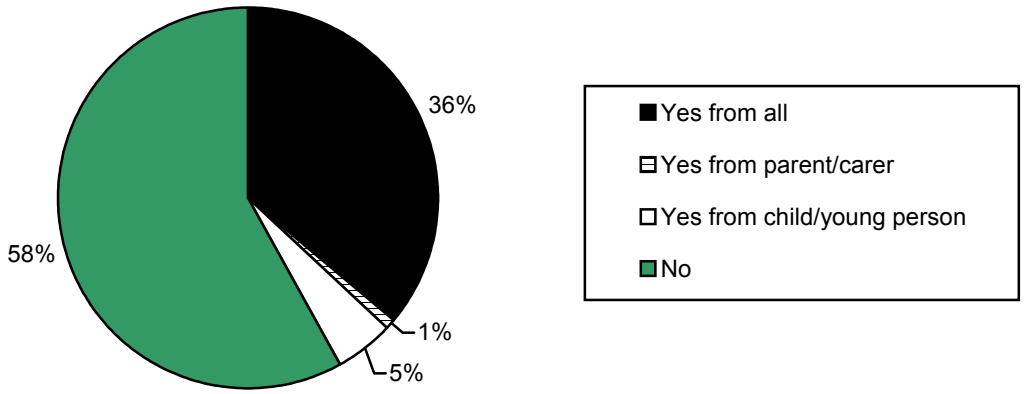
3.25 **The key findings of STANDARD 1.3 are:**

- only 36% of YOTs described having arrangement to elicit feedback from children and young people and their parent(s)/carer(s)
- only 23% of YOTs reported monitoring safeguarding arrangements, either within YOTs or between the YOT and its partners.

Criterion: ***The management board ensures that the extent to which children and young people and their parent(s)/carer(s) feel satisfied with safeguarding arrangements is monitored and evaluated.***

3.26 The audit response to the question linked to this criterion is shown in Figure 8 below.

Figure 8: Feedback arrangements: Source: Audit



Commentary

- It was of concern that the majority of YOTs did not gather feedback in these areas, although a number said that the questionnaire had given them food for thought and that they would be reviewing their arrangements.
- Of those YOTs who replied 'Yes from all', few provided further details on how they went about eliciting feedback.
- The main source of feedback from children and young people quoted was interactive questionnaires, which YOTs felt provided a better option for asking about children's and young people's views than paper and pen-based exercises.

Good practice example:

Examples from those who did elicit feedback included West Berkshire and Durham, who used feedback forms; and Sheffield, who referred to monthly meetings with remand foster carers as a means of consultation.

3.27 Of YOTs inspected, the majority had not been successful in eliciting feedback that covered safeguards, though it was encouraging to learn that some attempts had been made. Suffolk had tried to use a questionnaire to gauge children's and young people's views, but had had insufficient returns to make it practicable. It was unclear how many questionnaires had been distributed initially, and by what means. Oxfordshire described plans to monitor parent(s)/carer(s) feedback, but said that it had encountered difficulties with its case recording software in taking this work forward.

Good practice example:

Leeds had a leaflet for young people on how to feedback both compliments and complaints to the YOT which included a timescale for responding. They were also creative in using a 'mini-flyer' which had three faces on it, denoting 'good', 'OK' and 'poor', as a simple means of getting the views of children and young people. Blackpool similarly used a 'Comments, Complaints & Compliments' pamphlet.

Criteria: ***There are single agency and joint monitoring systems in place to ensure that safeguarding arrangements are robust, consistently applied and take account of diversity.***

Monitoring information is used to improve safeguarding outcomes: YOTs have processes in place to identify their organisation's strengths and weaknesses and inform future practice, with evidence of changes and improvements to practice.

3.28 We were disappointed to find that only 23% of YOTs reported monitoring safeguarding arrangements.

3.29 Few YOTs monitored issues other than those required by the YJB such as the number of secure remands. Several YOTs reported collecting data but not aggregating them for analysis as a means of assessing and improving services. However, we recognise that YOTs are maturing organisations and monitoring and evaluation are still developing. This makes the role of performance and operational managers in overseeing cases particularly important.

3.30 Amongst those YOTs who reported monitoring beyond the requirements of the YJB, areas most frequently referenced included:

- the service carried out by AAs
- the number of children and young people held overnight in police custody
- PSR congruency (proposals v. outcomes).

3.31 For the inspected YOTs, the findings resembled the national picture. All five were generally able to show how the use of BSS compared to other bail options and to custodial and secure remands in their area. The recording of this data also allowed the YOTs to compare remand episodes for minority ethnic children and young people against their white counterparts, and boys against girls. All YOTs shared the aim of enhancing children's safeguards by promoting community alternatives to custody through the development of robust BSS programmes. The extent to which they were successful is discussed in Standard 3.

3.32 Oxfordshire and Wessex gathered information against a performance agreement with SCS regarding timescales for responding to referrals from the YOT. Oxfordshire planned to focus on outcomes of referrals, but had not yet decided how best to keep track of this information.

Case studies:

- Oxfordshire reported monitoring custodial remands following a zero-based budgeting exercise commissioned by the steering group, which had established the need to increase funding for the BSS team.
- The custody rate in Leeds, which was historically high, had been investigated by consultants who had shown that the key factor was the serious nature of the cases going to court, rather than the YOT's failure to promote acceptable alternatives. Nonetheless, Leeds had since endeavoured to increase their input into magistrates' training to improve courts' understanding and confidence in the YOT and effect a reduction in custodial remands. They had also recently appointed another court officer, with the intention of improving services to the court and children and young people.

3.33 The YOTs inspected did not routinely monitor the time spent by children and young people in police custody and therefore were not able to use this information in discussions with the police regarding efficiency improvements and reducing the average time spent in custody.

3.34 However, three YOTs had begun to look into monitoring the time spent by AAs at the police station. The contractors for Wessex's Isle of Wight team had used this information to inform practice, in that AAs rang custody sergeants to ask when the solicitor was expected and scheduled their arrival around this time. This was practical as there were relatively few call-outs for AAs on the Island, compared to other YOT areas. Leeds had undertaken a 'dip sample' of the extent to which the police attempted to contact the responsible adult(s) before contacting the YOT AA service, but had not as yet followed up the findings of the survey.

Description of STANDARD 1.4: Resources

Outcomes for the safeguarding of children and young people are supported by the appropriate allocation of resources.

3.35 **The key finding of STANDARD 1.4 is:**

- Policies and practice protocols address the provision of translation and interpretation services to children and young people and their parent(s)/carer(s) who communicate using British Sign Language or for whom English is a second language.

3.36 **The key findings of STANDARD 1.4** that relate to a) children and young people in police custody and b) bail services are explored in **Standards 2.6 and 3.1** respectively.

Criterion: ***Policies and practice protocols address the provision of translation and interpretation services to children and young people and their parent(s)/carer(s) who communicate using British Sign Language and/or for whom English is a second language.***

3.37 Across the inspected YOTs, we were told that the police would arrange interpreters and signers for children and young people at police stations, and that a similar service

would be provided by the courts. The dedicated asylum seeker worker in the Oxfordshire team reported that she had used her own contacts to develop BSS packages where appropriate.

3.38 None of the YOTs inspected described any problems in accessing interpretation services, and we found no evidence that there were difficulties. However, one YOT said that it also had access to interpreters 'out of hours', but that this was expensive. We were not clear whether or not this resource issue had prevented the YOT using the service out of hours. Nonetheless, we felt that the service needed to be viewed as an important one for children and young people, and funded accordingly.

Description of STANDARD 1.5: Staff supervision, development and training

Staff contribute to the safeguarding of children and young people.

3.39 **The key findings of STANDARD 1.5 are:**

- there were some strong examples of comprehensive training programmes relevant to safeguarding issues for YOT staff, often in partnership with ACPCs
- a minority of YOTs had staff and volunteers working with children and young people who had not been CRB checked
- volunteers acting as AAs did not receive regular supervision.

Criterion: *Staff have appropriate skills, knowledge and understanding to safeguard the rights and welfare of children and young people.*

3.40 80% of YOTs reported that they provided staff training specific to safeguarding. The majority of this training was through ACPC channels. Of YOTs in the analysis:

- East Riding said that all staff were required to undertake ACPC level I and II training as part of their induction
- Norfolk stated that they had mandatory 'in-house' annual child protection training and that staff had attended county road shows on safeguarding children and developments in the county
- West Berkshire described placing an emphasis on safeguarding issues during staff induction, which involved close work with partner agencies.

3.41 Although the vast majority of YOTs described training arrangements that were embedded in staff induction and professional development, the level of provision varied enormously, with a fifth of YOTs reporting that they did not have any such training. A small number of YOTs explained that they were in negotiations to improve the position, but very few indicated that the situation was likely to change for the better. This was of concern.

3.42 Of the inspected YOTs, it was encouraging that staff appeared to be able to access relevant training and there were some examples of good practice.

Good practice examples:

- Wessex staff received a comprehensive 'foundation training programme', which included child protection training.
- Oxfordshire and Suffolk were both on the YJB's human resources strategy learning for their regions and had well-defined staff development processes.
- As part of their induction, new BSS staff in Suffolk were taken for a tour of nearby Warren Hill YOI. They were therefore in a better position to respond to the concerns of young people at risk of remand.
- Suffolk, Wessex and Oxfordshire had also distributed copies of *Every Child Matters* to staff.
- All Blackpool's staff had received training, which was further supported through regular supervision. There were, however, concerns that sessional staff used by the EDT were not as well prepared.

Criterion: *Staff are regularly supervised in accordance with their developmental needs in relation to safeguarding issues.*

3.43 Supervision of YOT staff appeared to be variable across the inspected YOTs, although the majority of staff reported that they received regular supervision through which development needs linked to safeguarding children and young people would be identified. For example, Suffolk and Southampton had thorough and fully implemented staff supervision and appraisal practice processes.

3.44 Where volunteers were used as AAs, there were no 'formal', fixed supervision arrangements in place. Instead, supervision tended to be based on an 'open-door' policy, whereby AAs would ring the coordinator or YOT management and arrange supervision. Alternatively, managers would phone the next day and AAs could discuss their work.

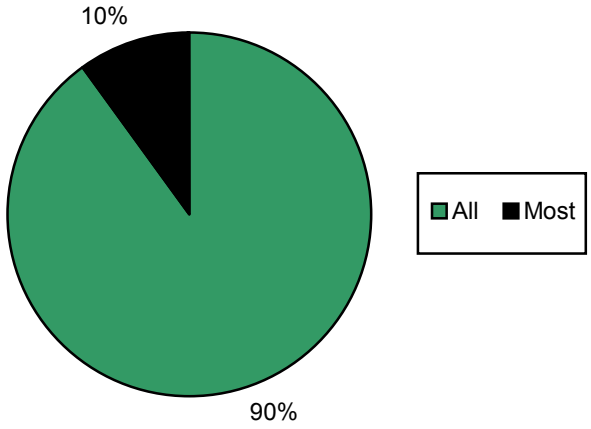
3.45 At each of the YOTs, all the AAs to whom we spoke said that their managers were very approachable and that they felt fully supported. The AA interviewed on the Isle of Wight simply described the help and encouragement he had received as 'excellent'.

3.46 However, we felt that it should not be incumbent upon the AAs to decide when they needed to seek out supervision, no matter how approachable their managers were. We felt YOTs should look at offering supervision sessions to AAs where they could discuss personal and professional development on a regular basis.

Criterion: *Staff are appropriately qualified and have had a criminal record check.*

3.47 The response to the audit question linked to this criterion is shown in Figure 9 below.

Figure 9: YOT staff and CRB checks



Commentary

- 90% of YOTs who replied stated that all their staff had had a CRB check.
- But 10% still had employees who had not been CRB checked, which was of concern, particularly given the recommendations of the Bichard Report that all individuals who have contact with children and young people should be checked at the enhanced level of disclosure.
- In addition, it was not clear whether the CRB checks completed had been reviewed in the last three years or when an individual changed jobs between agencies.

3.48 All staff in the five YOTs inspected were said to have been CRB checked, but only Oxfordshire confirmed that this had been at the top 'Enhanced' tier and that checks were reviewed regularly. Blackpool and Suffolk were planning to introduce a system whereby all CRB checks were regularly updated.

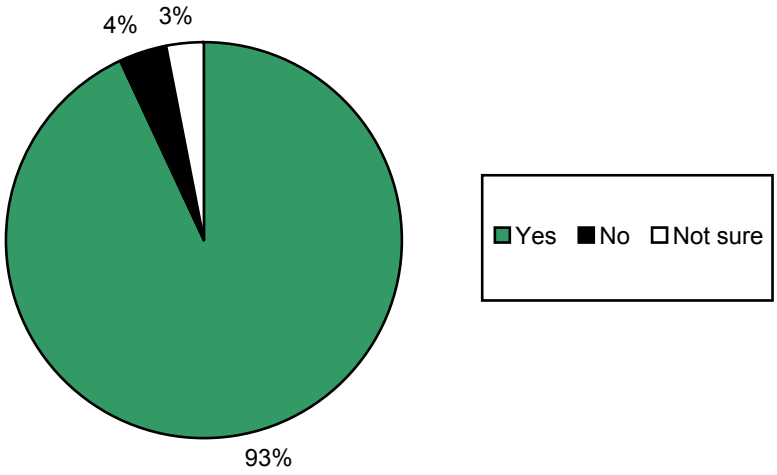
Good practice example:

Enhanced CRB checks had been undertaken in Oxfordshire on all staff and volunteers prior to their commencement of work with children and young people and had been updated in accordance with local guidance.

Criterion: ***Volunteers are appropriately trained, available for YOT activities and have been through CRB checks.***

3.49 We also asked about volunteers and contract staff. The response is shown in Figure 10 below.

Figure 10: Contract staff who have contact with children/young people and CRB checks



Commentary

- The number of YOTs saying 'Yes' to this question, though high at 93%, was not the required 100%.
- Encouragingly, the 'No' respondents commented in their questionnaire that this was an area that they recognised required attention.
- We were surprised at the small but significant number of YOTs who replied that they were not sure whether their volunteers and agency staff had been CRB checked, and reported that they intended to go back to their protocols and SLAs to check. We had hoped that this would be an area that YOTs were fully cognisant.

3.50 This question for the five YOTs inspected was primarily concerned with volunteers who acted as AAs and remand foster carers.

3.51 The picture was identical to that of staff CRB checks, except that the respective contractors were responsible for the checking of volunteers in Blackpool, Suffolk and Wessex.

3.52 With regards to training, all YOTs inspected had an AA and, in the case of Wessex and Suffolk, a foster carer training programme.

3.53 AA training: The AA induction training for Suffolk and Oxfordshire was particularly comprehensive, with the training carried out over several days and a variety of experts from different fields presenting to the trainees. All training programmes seen included sections on the criminal justice system and relevant legislation, the role of the AA, communication skills and methods of identifying and responding to welfare-related issues.

3.54 Diversity did not generally form an integral or additional part of the AAs' training. The Suffolk YOT AA provider appeared to be the only one to have introduced a diversity module into its training for new volunteers and planned to extend this to its existing volunteers.

3.55 All the AAs interviewed described 'shadowing' a more experienced colleague during their induction period, a process they found useful in building confidence in the role. Training to meet ongoing professional development needs was said to be more sporadic, with plans to run quarterly 'update' sessions in YOTs not routinely taking place. This was an area that we felt required a more consistent approach from YOTs.

3.56 Remand foster carer training: Suffolk had recently taken the decision to bring their remand foster carers 'in-house', after having previously been coordinated by a national charitable organisation. As a result, they were in the process of developing a new framework for induction and training. We were told that foster carers would receive an intensive basic training 'Skills to Foster' course provided by Fostering Network, which included child protection and whistle blowing, supplemented by one-to-one training on remand aspects delivered by a practice manager. They would then be in a position to access the ongoing foster carer training system in place for existing remand foster carers.

Good practice example:

The remand foster carers in Southampton (Wessex) who were managed by a national charity had all been checked and given an additional extensive assessment and training period lasting up to six months. The 'Skills to Foster' programme developed by the Fostering Network was used in their training. In addition to the 'Skills to Foster' training described above, foster carers in Wessex had supervision sessions with a child guidance consultant psychiatrist three or four times a year.

Criterion: ***There are procedures in place to respond to both historical abuse allegations and those against staff or other non-family members.***

3.57 Each of the YOTs inspected was able to describe what they would do in the event of an allegation being made or coming to light. These processes were generally governed by local child protection and ACPC guidelines. For secondees, the parent body's procedures would be used. There was no evidence that this system was inadequate, though it had not often been employed.

Good practice example:

The Suffolk YOT Head of Service described what sounded like a useful system, whereby they had established an 'on-call' rota amongst the practice managers, so that staff knew who to refer matters to. He stressed that staff should be aware of the need to consult with a manager first of all and to do this swiftly.

Recommendations

The YJB should:

1. *support YOTs in discharging their responsibilities by advising them on their strategic role on Local Safeguarding Children Boards and provide direction on work to safeguard children and young people.*

YOT managers should:

2. *ensure that they are in the forefront of planning with partners for Local Safeguarding Children Boards*

3. *establish or improve arrangements to monitor performance in relation to safeguards issues in conjunction with key partners such as the police and social services*

4. *set up and maintain a process whereby all staff and volunteers who are involved with children and young people are CRB cleared at 'enhanced' level and have this clearance reviewed every three years*

5. *ensure that induction, training and supervision for both staff and volunteers addresses safeguards issues, including training to recognise signs of abuse or neglect.*

4. STANDARD 2: Work with children and young people in police custody: Appropriate adult and PACE (38) 6

Description of STANDARD 2.1:

Parental/carer responsibility is reinforced.

4.1 **The key findings of STANDARD 2.1 are:**

- in the majority of cases, YOT affiliated AAs were only used in exceptional circumstances
- the reasons for a police referral to the AA service were not always noted
- there was evidence that parent(s)/carer(s) were kept informed about the outcome of the interview in 63% of cases
- information for children and young people and their parent(s)/carer(s) about YOT services and parental responsibility was not readily available in police stations.

Criterion: *Information on parental responsibilities is readily available at the YOT and police station.*

4.2 We asked police representatives in the five areas inspected if they had information from the YOTs for children and young people and their parent(s)/carer(s), in the form of leaflets, posters or flyers, and whether this was available in police stations. This information could include: how to obtain legal advice; services available through the YOT; location of the court and consequences for breaching bail and/or not attending; information relating to reprimands and final warnings. None of the custody sergeants to whom we spoke were confident that they had any YOT produced information of this sort, although some had information of their own.

Case studies:

- Leeds had a leaflet on young people's rights and a guide to give to family members acting as AAs.
- On the Isle of Wight, the custody sergeant told us that they did have such leaflets in the old building, but had only recently opened a new custody suite and knew of no plans to reintroduce them.
- Suffolk YOT had a leaflet on acting as an AA, but it did not appear to be widely available.

4.3 We felt that YOTs should continue to liaise with the police in order that this information be produced and made available to parent(s)/carer(s) as soon as possible.

Criterion: ***Every effort is made to contact parent(s)/carer(s) to secure their attendance where appropriate. AAs are only used in exceptional circumstances.***

4.4 We were pleased to find that generally, the police used the AA service only when suitable alternatives were not available.

4.5 Similarly, all of the AAs we spoke to were confident that the police used the YOT service as a last resort. One observed that it was not uncommon for the YOT to be called when it was found that the family member who had been asked to attend was not, in fact, fit to act as an AA.

4.6 However, across the inspected YOTs, the police's reasons for requesting an AA were noted in the PACE monitoring forms in only 59% (of 28) cases. YJB national standards dictate that the police explain to the YOT on referral, why the parent(s)/carer(s) were not available, and that the YOT then notes these reasons. Considering this requirement, we were surprised that AAs frequently attended police stations without any explanation of why they were required. We felt it might have been because they took it on trust that the police had made attempts to contact family or friends first and did not feel in a position to challenge any decision regarding their involvement.

4.7 In YOTs where a check would routinely be made on whether the police had made attempts to secure parent(s)'/carer(s)' attendance, there appeared to be two points at which this 'check' would occur. First, when the police told the YOT to request an AA, and secondly, when the AA arrived at the police station and could then examine the custody record.

Good practice examples:

- In Leeds their 'first stage' checking included the AA coordinator responsible for brokering the requests from the police, asking the police to confirm who they had already contacted, prior to them ringing the YOT. This action was supported by the custody sergeant.
- An example of the 'second stage' of checking was Blackpool, where we were told that the police expected to be asked at the station whether or not they had contacted other potential AAs, and consequently "nine out of ten times" they did so.

Criterion: ***Parent(s)/carer(s) are kept informed about what has happened.***

4.8 This responsibility fell either to the YOT or the police, although it was not always clear who was held accountable for this task. This appeared to be because the arrangement was generally based on 'agreed local practice', possibly borne out of who had historically done the job in the past. Only Wessex and Leeds had clarified this agreement in their protocols.

4.9 It was difficult for us to gauge which option was better, in that even where the relevant box on the PACE monitoring forms had been ticked (indicating that a letter had been sent to parent(s)/carer(s)), a copy of the letter was rarely included in the papers.

4.10 In the file read, there was evidence that parent(s)/carer(s) were informed of the outcome of proceedings in 63% of cases. Of these, only 53% were informed in writing, although of those that were, all but one were informed within one working day in accordance with the YJB national standard.

4.11 However, even where the YOT staff or volunteers acting as AAs followed the national standard, we still had concerns that it was insufficient. For example, if a child or young person was arrested on a Friday evening, held overnight and then required by the police to attend court on Saturday, a letter might not arrive with his or her parent(s)/carer(s) until the following Tuesday. By which time the child or young person could have been remanded to custody.

4.12 YOTs should examine the systems they use to keep parent(s)/carer(s) informed, and reassure themselves that they are able to do so promptly and effectively, regardless of the circumstances of the child's or young person's arrest.

Description of STANDARD 2.2:

Attempts are made to achieve a suitable 'fit' between the AA and the child or young person.

4.13 **The key findings of STANDARD 2.2 are:**

- there were some good attempts by YOTs to 'match' the AA to the specific needs of the child or young person, despite limited numbers of AAs
- AA access to YOT and SCS databases, and therefore the amount of information on the child or young person available to the AA, varied considerably between YOTs. Arrangements in several YOTs did not allow for AAs to be made aware of specific information about the child or young person, prior to attending the police station.

Criterion: *AAs are representative of the community they work in.*

4.14 The inspected YOTs and their contractors reported that this was difficult in the extreme, primarily due to lack of numbers: the smaller YOTs such as Blackpool and the Wessex Isle of White team had only two or three active AAs. Each YOT described problems with recruitment and said they ran almost constant campaigns.

4.15 We did not know the reason for the difficulties experienced by the YOT in recruiting volunteers, particularly from the black and minority ethnic communities. We wondered whether it was due to a lack of effective engagement by the YOTs with these communities, or if there was some reluctance amongst members of black and minority ethnic groups for a role that might be perceived as being at the heart of the criminal justice system. We felt that these possibilities needed to be better explored by the YOTs, ideally in conjunction with the police, to improve the level of representation amongst volunteers.

Case studies:

- The Isle of Wight contractor reported that recruitment of a representative pool of AAs was particularly difficult due to the profile of the population on the Island. He commented that retired people were actually amongst the best candidates for AAs posts because of their availability.
- Blackpool and Oxfordshire used their own staff to act as AAs. In Oxfordshire, which had a smaller than national average multi-ethnic population, 7% of the entire YOT workforce were from black and minority ethnic backgrounds, so the proportion was reasonably representative.
- Leeds YOT, who managed its volunteers directly, stated that it continually advertised for volunteers using a variety of media outlets, including advertising in community centres. Although it reported having 'a few' black and minority ethnic volunteers, managers observed that, "recruitment is tough and we are not in a position to turn away volunteers".
- Suffolk described having a spread of ages between 20 and 60, with most volunteers in their 40s and 50s, and a gender balance of approximately 50:50. It advertised in all the local papers, volunteer bureaus and police stations, and a local agency had been asked by the YOT to contact community leaders to promote AAs.

Criterion: ***Consideration is given to matching the AA to the child's or young person's specific needs and circumstances.***

4.16 Small pools of AAs and the limitations of the rota system meant that YOTs and AA contractors thought this unrealistic. The Isle of Wight contractor suggested that attempting to match the AA with a child or young person was also not desirable, although he did comment that if the child or young person was found to have particular health needs then the AA would contact the medical staff. We felt that, where circumstances prevented any type of matching, it was crucial for AA training to equip AAs with the knowledge and confidence to deal appropriately with the child's or young person's individual needs. The AA interviewed from the Isle of Wight confirmed that this had been his experience, in that his training had informed him about which agency he should contact if he needed guidance in addressing a particular need, and when to refer back to the YOT.

4.17 However, whilst we understood that resources hindered attempts to actually 'select' an AA according to a child's or young person's needs, we felt that there was risk attached to dispensing with the preliminary process of finding out what those needs were. If a child or young person was found to have a language problem, for instance, the AA could then attend the interview forewarned and possibly with the contact details of suitable interpreters. It would be of benefit for YOTs to explore how contracted AAs could be better informed about the children and young people seen at the police station.

4.18 Both Oxfordshire and Suffolk thought some degree of 'matching' desirable and were able to give the issues some consideration. Suffolk reported that it tried to ensure that more experienced AAs handled complex cases, although its ability to do this was limited by their availability.

Good practice example:

Oxfordshire had more flexibility in that it could decide to use the allocated YOT officer (if the child or young person was already on an order) rather than the duty AA, assuming the allocated officer was AA trained. In the case of children or young people being charged with sexual offences, Oxfordshire would attempt to use OXYAP trained staff as the AA, to safeguard the welfare of both the individual and the AA.

Criterion: ***When a request is made, the AA identifies whether or not the child or young person is known to the YOT or SCS and in what capacity.***

4.19 The extent to which this was possible in the YOTs was determined by whether or not the AA, or the 'broker' who dealt with the call, had access to the YOT or SCS information systems, or routinely liaised with the YOT or SCS. This seemed to be less likely where the AA service was contracted out to a provider, in that the contract did not cover volunteers' access to such information. In Suffolk, it was not part of the remit of the switchboard staff (who were the first point of contact) to ask about the status of the child or young person, and so the AA volunteers would only know the child's or young person's name, age and gender. This system did not seem to worry the AAs, although we had some concerns about the prospect of relevant information on the child or young person being overlooked if the AAs had to rely on what information they could gather at the police station.

4.20 Similarly, Leeds's contracted volunteer AAs did not have access to the SCS or YOT systems and got most of their information on the child or young person on attendance at the police station. We were told that there were plans for AAs to be given access, but no timescale had been set.

4.21 We felt that finding a way for AA volunteers to gather appropriate background information on a child or young person should be a priority for YOTs.

4.22 The Isle of Wight contractor had a good system of identifying if the child or young person was known to SCS or a Looked After Child at the 'broker' stage and, if so, requesting that SCS send an AA. It felt that this helped ensure that the child or young person received a better service from someone who would have the child's or young person's details more easily to hand.

Description of STANDARD 2.3:

AA service is timely.

4.23 **The key finding of STANDARD 2.3 is:**

- an AA service, whether through the YOT, the YOT's contracted service provider and/or the EDT, was available in keeping with PACE guidelines.

Criterion: ***AA provision is available seven days a week, 24 hours a day (this criterion was not in the YJB's 2004 National Standards for Youth Justice Services).***

4.24 This criterion created some controversy in that PACE guidelines hold that the arrest and interview process for children and young people should mirror an ordinary day, and therefore most of the inspected YOTs' AA provision reflected this. AAs were available to attend interviews between approximately 09.00 and 22.00. After approximately 17.00, this service was often provided by the SCS EDT.

4.25 The NAAN, who represent approximately 80 AA services, YOTs and police forces, state that their preference would be for AAs to limit their availability to between 08.00 and 24.00. NAAN is currently working on national standards for AA training and service delivery, which it hopes will provide guidance for both affiliated AA services and a 'level of service expectation' to services looking to 'sign-up'. The standards ought to be operational by 2006.

4.26 All of the YOTs and contractors inspected had decided that children and young people ought not to be interviewed after 22.00 and hence, AAs were not available after that time. (This was also in keeping with PACE guidelines that required children and young people to have an eight-hour rest period without interview.) However, the police representatives in some of the areas visited did not seem to be fully aware of these constraints, and expressed frustration that AAs would not attend interviews after 22.00. This suggested that better communication was required between YOTs and police on this issue.

4.27 Even where the police were aware of local arrangements around AA provision, their frustration at keeping children and young people in custody overnight led some representatives to comment that they would appreciate what they termed a 'client led' service, i.e. if a child or young person was arrested late in the evening or early hours of the morning and was clearly awake, aware and fit for interview, then they would be better served by being interviewed as near to that time as possible. Though no longer accepted practice, the service offered in the Isle of Wight under the previous contractor was described in these terms, although its success depended upon having an AA coordinator who was willing to go out to attend interviews at any time. This approach would be logistically more difficult in a busy YOT area, even if it were decided that interviewing children and young people in the early hours of the morning was appropriate and did not contravene PACE guidelines.

4.28 A further issue that led to some dissatisfaction from the police was the 'transition period' during the handover of responsibilities from the AA day service to the EDT evening service, usually between 16.00 and 17.00. The custody sergeant interviewed in Oxfordshire commented that AAs were understandably less willing to come out to the station between those times, and that EDT would not consider it their duty until after 17.00. He suggested split shifts as a possible solution.

4.29 Given the frequency with which this area came up in discussion, liaison between the police, YOT, AA provider (where relevant) and EDT would be worthwhile.

Good practice example:

AAs in Oxfordshire had already planned to address this situation. They reported that they were not happy with the existing level of communication with the EDT team, but expected that this would get better when the new business plan for the service was implemented.

4.30 In terms of the timeliness of AA provision, attendance information was recorded in 17 out of a total of 30 cases and all 17 were within the two hours required by the Youth Justice national standard, which was encouraging. However, this figure suggested that for the remaining 13 cases, either a) attendance information was not recorded because of a gap in the recording process or, b) information on attendance was only recorded when AAs were 'on time'.

4.31 We were not able to determine which option applied and would recommend that YOTs monitor timeliness of attendance more consistently.

Description of STANDARD 2.4:

AA contributes to the safeguarding of children and young people in police custody.

4.32 **The key findings of STANDARD 2.4 are:**

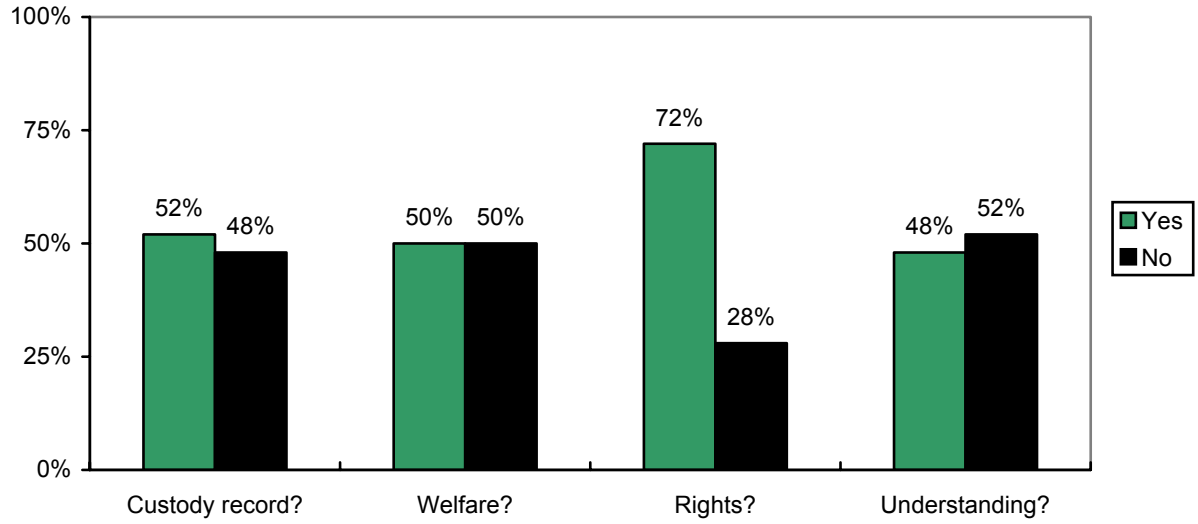
- all AAs received training that covered PACE requirements
- recording of gender, ethnicity and wider diversity issues on PACE forms was patchy
- there was evidence that AAs had checked and confirmed whether children and young people were informed of their right to speak to a solicitor in only 71% of cases
- there was some anxiety expressed by YOTs and AA providers around whether or not AAs should attend interviews without a solicitor being present
- the 'feedback loop' between AAs and the YOT, particularly for children and young people coming into contact with the criminal justice system for the first time, required greater clarity.

Criterion: *The AA ascertains whether the welfare of the child or young person is safeguarded in the police station in accordance with PACE.*

4.33 From the training materials, it was clear that all the training offered to AAs through YOTs included an overview of PACE requirements. Further, all the AAs interviewed appeared to understand the appropriate checks that needed to be made at the police station, to ensure that the child or young person had been treated properly. However, it was not always apparent from the PACE forms read by inspectors that these checks were being made.

4.34 The data from the file read questions linked to this criterion are shown in Figure 11 below.

Figure 11: Evidence that the AA had checked: custody record; childs or young person's welfare; if they had received notice of their rights; their understanding of the process



Commentary

- As can be seen, there was evidence that AAs checked whether children and young people had received notice of their rights in over 70% of files read (21 cases).
- Evidence that AAs had verified the custody record, checked on the child's or young person's welfare (e.g. that they had been offered food and drink) and that they understood the process was weaker, with results of approximately 50%.

4.35 When asked about this area in interview, AAs emphasised that they did carry out such checks, but did not consistently record that they had done so. Some AAs wrote on their forms or ticked a box to say that they had 'interviewed the child or young person' prior to the police interview, but recognised that this only implied that required welfare checks had taken place, but did not specify what the conclusions were. Recording needed to improve in order to better evidence the work that AAs said they did at the police station. Much could be achieved by amending the PACE monitoring forms used.

4.36 The police were consistently positive about the work of the AAs at the police station, which was good to hear. The Suffolk custody sergeant spoke highly of the AAs with whom she worked, praising them for their dedication. On the Isle of Wight, the custody sergeant stated that, "we know each other – we trust them and they trust us. We have a very good working relationship". The Southampton custody sergeant agreed that AAs did all the relevant checks and supported children and young people well, although they were disappointed that the new providers were not yet fully functioning.

Criterion: ***The AA promotes the child's or young person's access to, and use of, legal assistance.***

4.37 All five YOTs had a policy of AAs promoting the child's or young person's access to, and use of, legal assistance. AAs stated that they checked whether or not a solicitor had been called, and in some cases asked this question of the police before attending the police station so that they could plan their time of arrival. Oxfordshire's AAs reported that their relationship with solicitors had improved since they had moved onto a fixed rota, in that they had become more familiar with the solicitors who tended to work the same days. This increasing familiarity had served to raise awareness of their respective roles.

4.38 According to AA records, the child or young person was informed of their right to contact a solicitor in 71% of cases, but there was evidence that the child or young person had been asked if they would like to contact a solicitor other than the duty solicitor in only 5%. Best practice would suggest that children and young people be given the option of contacting a known solicitor, e.g. family's solicitor. Poor recording may again have been a factor in these findings.

4.39 If a solicitor was not able to attend, or a child or young person was categorical in not wanting one present, the issue of whether or not AAs would still attend the interview varied across the YOTs. The majority of AAs would attend, but with the proviso that they could overrule any objections and request a solicitor if they felt that it was in the child's or young person's best interest, e.g. if they appeared particularly vulnerable.

4.40 However, this had led to some difficulty in Suffolk, where AAs stated that they felt the police did not like them to 'push' for a solicitor. They speculated that the police's objections were due to the fact that requesting a solicitor often increased the length of time that the child or young person was in custody, and that this delay was unnecessary where they pleaded guilty.

4.41 These comments raised the possibility that AAs might come under pressure from the police to help them expedite interviews by not 'holding out' for a solicitor. This pressure could, in turn, lead to volunteers attending interviews against their better judgement. Although AAs in Suffolk were reportedly willing to conduct an interview without a solicitor, they preferred to at least telephone a solicitor and discuss the case before hand. They saw this as a reasonable compromise, as it reduced the likelihood of a persistent young offender, for example, jeopardising his or her own case through complacency borne of familiarity with the system. However, we still had some concerns about this position, in that AAs could find themselves blurring the boundary between their advocacy role and the legal position in the case.

4.42 In practice, we were told that potentially awkward situations were frequently resolved between AAs and the police at the station, as children and young people usually agreed to follow advice and have a solicitor. Despite this, the Suffolk contractor's AA coordinator felt, and we would agree, that this area remained an issue to be addressed between the YOT, the police and themselves, at least in terms of establishing agreed guidelines throughout the county. The YOT had endeavoured to do so by attempting to seek the advice of the YJB but, at the time of the inspection, the situation remained unresolved.

4.43 The NAAN commented that, whilst it was aware that different schemes had different policies on attendance, it felt the movement was towards AAs not attending if a solicitor was not present. The NAAN did not intend to make it a requirement in the national standards for AAs not to attend without a solicitor, but suggested that it would like to see very clear written reasons why the interview went ahead without a solicitor. Under PACE, an interview cannot take place without an AA in attendance.

Criterion: ***There are arrangements for ensuring that children and young people get home safely.***

4.44 Making arrangements for getting children and young people home safely after their interview with the police was, in the main, the police's responsibility. However, these arrangements were not always confirmed in writing: only Suffolk and Oxfordshire had this arrangement set down in policy; other inspected YOTs relied on agreed practice.

4.45 Protocols themselves did not seem to guarantee that arrangements were straightforward: the Oxfordshire custody sergeant described this area as a "sticky one", in that the police wanted to sign a child or young person off into the care of the YOTs via AAs, whereas AAs were concerned about the practicalities of taking them home. He summarised the situation by saying that each case was judged on its merits. The YOT AA coordinator asserted that arrangements were usually dependent on the child's or young person's age. We felt that the protocol itself required greater clarity and practice needed to be monitored to ensure compliance.

4.46 Whether or not the child or young person had the wherewithal to get home after the interview was noted on only 52% of PACE forms. Where the child or young person had no obvious means, the AA clearly brought this to the attention of the police in only two out of the seven relevant cases. This was of concern.

4.47 We wondered whether this finding was due to the 'informality' of some YOTs' agreements with the police regarding role and responsibilities, or whether it was a recording issue. Whatever the reason, we felt this gap in communication increased the risk of a child's or young person's circumstances being overlooked.

4.48 The situation was more complicated when the child or young person was not able to return home or was a Looked After Child. Here, finding suitable accommodation often late at night was a problem and concern for both the AAs and the police, who were understandably reluctant to bail any child or young person without an address to go to.

4.49 The issue of children and young people being appropriately clothed for release on bail, or to appear in court after their own clothes had been taken for forensic examination, varied across the YOTs. We were told that in some cases children and young people were provided with what was viewed as inadequate and inappropriate paper clothing. This was of concern. HMIC's expectations are that police forces only use paper suits where the child or young person has refused to wear alternative clothing supplied by friends, relatives or the police themselves; to do otherwise would be to contravene the child's or young person's human rights. Police guidelines covering this practice are currently in development.

4.50 In one YOT, the situation was confusing as the YOT and the police representatives interviewed reported different practice regarding children and young people being released in these paper suits. This was not acceptable. Procedures therefore needed to be reviewed and agreed between the YOT and the police as a matter of urgency.

4.51 There were several encouraging examples, however, of police and YOTs going to lengths to avoid the use of paper clothing. The police representative on the Isle of Wight said that his officers went out to a local store and bought clothes for children and young people, rather than have them released in paper suits.

Good practice example:

Courts in Southampton would not accept anyone in a paper suit. Local police therefore provided tracksuit bottoms and t-shirts or 'hospital' type green trousers and tops. This was felt to be a good initiative to dissuade the use of paper suits.

Criterion: ***There is satisfactory information sharing between the AA and YOT staff, on issues relevant to the safeguarding of the child or young person.***

4.52 Information sharing on safeguards issues seemed to be stronger where the child or young person was already known to the YOT: in these cases, the AAs could discuss the child or young person in question with their case manager prior to the interview, and feedback later. It was unclear how pertinent information on children and young people arrested and charged for the first time would find its way to the court officer or bail support worker whose role it was to complete Bail Assets. We had some concerns that, without a more reliable method of exchanging such information, useful information, which should inform assessments, was not always available to the court officer.

Case studies:

- In addition to verbal feedback to case managers, AAs in Blackpool, who were also members of the YOT's court team, would make an entry onto the computerised case records.
- Oxfordshire, Suffolk and the Isle of Wight were also clear about the need for AAs to feedback to the team, using PACE forms faxed to the YOT.

4.53 Suffolk AAs questioned the ability of their own PACE forms to flag-up important safeguards related information in more complex cases, and planned to make this information more easily identifiable.

Description of STANDARD 2.5:

YOT members of staff are proactive and help prevent children and young people being held unnecessarily in police custody.

4.54 **The key findings of STANDARD 2.5 are:**

- AAs were competent and confident enough to check and challenge PACE decisions where appropriate

- there was a lack of PACE beds reported, both amongst the inspected YOTs and in the wider YOT audit
- some AAs felt that SCS staff on the ground did not consider children and young people who had offended to be a particularly vulnerable group.

Criterion: ***YOT members of staff are competent and knowledgeable in order to check and challenge decisions to ensure that PACE criteria are properly applied.***

4.55 It was positive that, according to the police, AAs were generally competent and confident enough to check and challenge police decisions. AAs themselves reinforced this view.

4.56 AAs and coordinators were consistent across the inspected YOTs in their assertion that custody officers attempted to contact out-of-hours SCS, but that there were rarely, and in some cases never, appropriate secure beds available. Non-secure beds were also a rarity and this was a great source of frustration for the police and YOTs, leading as it did to more children and young people being held in police cells overnight.

4.57 The 2002 *Safeguarding Children* report found that professional staff from other agencies considered that SCS were not providing an adequate response when SCS judged a situation not to involve a high risk of serious harm to children and young people. An echo of this finding could be heard in the comments made by some AAs about the lack of attention paid by SCS to children and young people discharged with no accommodation. They felt that, although resources and thresholds were clearly an issue, SCS tended to stigmatise 'young offenders' and not recognise them as a vulnerable group.

4.58 These comments, taken in the light of the 2002 findings, suggested that a child or young person who had offended might be less likely to be considered at risk of self harm by SCS and, therefore, less likely to receive the appropriate support. However, exploring such questions with SCS staff or inspecting their practice in this area was beyond the scope of this inspection.

4.59 Nonetheless, this issue reinforced the potential benefits to be gained by YOTs and other key partners working together to try to circumvent the problem of children and young people involved with the YOT not being considered sufficiently high risk to warrant SCS intervention. There would be value in establishing a common understanding of thresholds for intervention.

Description of STANDARD 2.6: Resources

Outcomes for the safeguarding of children and young people in police custody are supported by the appropriate allocation of resources.

4.60 **The key findings of STANDARD 2.6 are:**

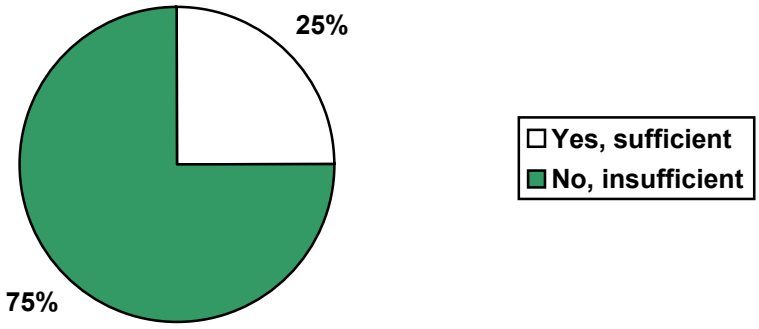
- there was reportedly insufficient accommodation for children and young people remanded to local authority care

- however, there was limited evidence that YOTs were actively engaging with appropriate housing partners.

Criterion: ***Attempts are made to ensure that there is suitable accommodation available to meet the needs of children and young people subject to PACE transfers and/or remands to LAA.***

4.61 The response to the audit question linked to this criterion is shown in Figure 12 below.

Figure 12: Is there sufficient accommodation available for young people subject to PACE transfers and/or remands to LAA?



Commentary

- Three-quarters of respondents stated that they did not have sufficient accommodation, with remand foster beds often being taken up by long-term care placements.
- In particular, a common concern amongst YOTs was a lack of suitable secure beds, preventing children and young people being transferred under PACE Section 38 (6), and leading to their detention in police cells overnight (see Standard 3.1).

4.62 YOTs commented that accommodation tended to be an area in which joint protocols 'fell down', in that agencies were tempted to 'wash their hands' of cases they considered out of their remit, rather than try to work collaboratively to solve the problem. There was also a feeling amongst some YOT staff that the provision for children and young people who had offended and whose family did not want them at home, was worse than for other groups of 'homeless' children and young people, as their history of challenging behaviours made providers nervous about taking them on. The prognosis was especially poor for children and young people under the age of 16 who were not considered at risk within the child protection legislation, and were therefore less likely to be picked-up by SCS or Council Housing Departments.

4.63 None of the inspected YOTs believed that they had sufficient LAA available to children and young people. However, there was limited evidence of YOTs being actively involved in local housing forums and strategic partnerships for children and young people leaving care. We felt that this was an area that YOTs could explore and try to develop. Given that children and young people coming through the YOTs cut across the

Children's, Care Leavers and Homelessness Acts, better multi-agency links between the YOT and the relevant agencies, whilst not leading necessarily to more suitable accommodation, would enable YOTs to make the best possible use of the resources available to them.

Good practice example:

Oxfordshire had a jointly-funded accommodation officer who had been trying to build capacity in the north of the county, as there was a history of children and young people being drawn to the city where there was better provision for the homeless. The officer had been successful in setting up a housing panel to engage the voluntary and public sector.

Recommendations

The YJB should:

- *clarify the wording of standard 2.8 in the National Standards for Youth Justice around notifying parent(s)/carer(s) following their child's or young person's interview with the police.*

YOT managers should:

- *review the effectiveness of any existing protocol between the YOT, police, AA provider and EDT (where relevant), with particular reference to:*
  - *daily 'coverage' of interviews with children and young people at the police station*
  - *attendance at interviews when there is no solicitor present*
  - *procedures around releasing children and young people in paper suits*
  - *accountability for getting children and young people home safely from police stations*
  - *arrangements for keeping parent(s)/carer(s) informed of the outcome of the police interview*
- *ensure that there is a mechanism for AAs to feedback to the YOT any concerns they had about children and young people*
- *improve recording of AAs' input at the police station, with particular regard to checks made on the welfare of children and young people*
- *liaise with key partners, particularly SCS, to establish a common language around and understanding of thresholds for intervention with children and young people.*

5. STANDARD 3: Bail issues: Bail information and bail supervision and support

Description of STANDARD 3.1:

Outcomes for the safeguarding of children and young people at court are supported by the appropriate allocation of resources.

5.1 **The key finding of STANDARD 3.1 is:**

- each of the YOTs inspected offered a BSS service but varied in their ability to routinely deal with children and young people appearing at adult magistrates' courts and before a judge in chambers.

Criterion: ***The BSS scheme has mechanisms to ensure they are aware of and are able to deal with any children and young people appearing at youth courts, adult magistrates' courts and before a judge in chambers.***

5.2 Early notification from the police enabled YOT staff to conduct preliminary checks on children and young people, and in the case of some smaller YOTs, determined whether YOT staff attended court at all. The YOTs inspected relied on the police to keep them abreast of children and young people held for production at court during the week. This information was usually conveyed by the police sending the arrest sheets to the YOT, although the YOTs said that they often had to ask for them, usually by a phone call, or else risk the information arriving too late to be of use. Worrying implications of this scenario included the YOT being unaware of children and young people appearing at court, who were then remanded without any assessment of their suitability for bail.

5.3 This arrangement seemed precarious to us, despite no actual evidence to suggest that YOTs were routinely missing children and young people held overnight, in that it placed excessive onus on the police. There was no guarantee that the information would be shared if the YOT was unable to instigate contact with the police each morning.

5.4 Each of the YOTs inspected offered a BSS service but varied in their ability to routinely deal with children and young people appearing at adult magistrates' courts and before a judge in chambers. The determinant factors were usually the size of the team and/or the throughput of the court.

5.5 One court representative interviewed commented that the magistrates had more confidence in the service provided by members of a dedicated court/remand team than those fulfilling the role as part of a rota, simply because experience and relationships counted for so much. Whilst it was understandable that familiarity with colleagues in the court could facilitate communication between agencies, we had some concerns that day-to-day arrangements for liaison were not sufficiently robust to counter balance a potentially dangerous over-reliance on individual relationships.

Case studies:

- Oxfordshire had a dedicated BSS team, i.e. full-time staff in role, which operated a duty rota to respond to all courts. The courts received a copy of this rota and declared themselves very happy with the service provided.
- Suffolk had one full-time court officer who fulfilled this role for all the courts, a service that was described as 'excellent' by a court representative. However, Suffolk were grappling with the issue of whether or not this dedicated role would result in over-reliance on one member of staff and a process of 'de-skilling' of other members of staff, who were not required in court. One option being considered was to train a back-up court officer.
- Leeds had the largest number of courts to service with the highest frequency of children and young people appearing in adult and Crown Court and was alive to some of the obstacles to safeguarding their interests as they passed through the courts. Although it had one court officer who had built relationships and expertise in judge in chambers' cases, on occasion children and young people were remanded directly from the Crown Court without a YOT presence or any paperwork. Although the rarity of this occurrence militated against a daily YOT presence in the Crown Court, the potential risks to a child's or young person's welfare when it did happen required a solution. Leeds was therefore hoping to forge closer links with the local probation area in order that it could be better prepared for this eventuality.

Criterion: ***The BSS scheme is available at weekends and bank holidays as well as during week days.***

5.6 Saturday courts presented the biggest problem, with not all inspected YOTs offering a service and difficulties described in accessing EDT provision. We saw different examples of practice, which usually relied on the police as first point of contact; it was apparent that YOTs would benefit from reviewing their provision for weekend court cover, preferably with input from the police and the court.

Good practice example:

Suffolk usefully had an emergency foster bed placement available for Saturday court.

Description of STANDARD 3.2:

Assessments of children and young people on their first appearance before a court are sensitive to their specific needs and address safeguarding issues.

5.7 **The key findings of STANDARD 3.2 are:**

- all YOTs inspected routinely checked the child's or young person's offending history and previous compliance on bail when determining their suitability for bail
- YOT staff saw building a good relationship with sentencers, the CPS and defence solicitors as key in helping to ensure that children and young people

were safeguarded between their first appearance in court and eventual sentencing

- the service provided to the courts by the YOTs inspected was universally described as 'excellent'
- Bail Assets were completed at the child's or young person's first court appearance in less than 50% of cases (40 cases in total)
- of those completed, only half were sensitive to safeguarding and diversity issues
- intervention plans contained within Bail Assets needed to better tailor to individual need
- recording in all aspects of the YOTs' duties required improvement.

Criterion: ***The health and welfare of the child or young person is taken into account when determining the availability of an appropriate bail address.***

5.8 YOT staff across the five YOTs reported that they tried to check a number of factors in determining the availability of an appropriate bail address. For example:

(a) whether the child or young person had any previous involvement with the YOT and, if so, their response to bail;

(b) whether they were known to SCS;

(c) parent(s)/carer(s) views, where appropriate;

(d) the police's opinion;

(e) the child's or young person's perspective.

5.9 With regards to (a), we were pleased to find that the YOTs had both checked the child's or young person's offending history and their previous compliance on bail in all cases, and that this information had informed the Bail Asset in 82% of cases. This was positive. One YOT described difficulties around liaison between the court officer and the YOT practitioners, who were team-based in different parts of the area. Where court officers were unable to contact case managers, they had to rely on obtaining information from the electronic file system which, due to poor recording, often did not contain the most up-to-date information on the children and young people in question.

5.10 With regards to (b), contact with SCS generally seemed to be initiated only where there was already some evidence that the child or young person was known to them. This implied that SCS links were missed in some cases, but staff reasoned that they only had a certain amount of time to make the necessary checks as they were working to the court's timetable. Whilst we could understand the need to prioritise when time was short, it was hard to see how it could not be resolved without commitment from both sides, given the repercussions of the court being unaware of a child's or young person's looked after status.

5.11 The quality of communication between the YOT and the courts clearly influenced the court's ability to make an informed decision about bail. As noted in Standard 1.1, each of the five YOTs described a good working relationship, which encouragingly was more than echoed by court representatives. As far as YOTs were concerned, this relationship

certainly assisted in children's and young people's health and welfare being considered of paramount importance in deciding on an address. Evidence of this is included in the following case studies.

Case studies:

- In Oxfordshire, a lack of remand beds or hostel accommodation often resulted in children and young people being bailed to their home address. One young person, in particular, was given unconditional police bail but the police asked the YOT to provide a voluntary BSS due to concerns around fire setting. When the young person appeared at court, the magistrates were reportedly so concerned about the risk posed by the young person that they were considering remanding them to a LASU or specialist open-bed unit. The YOT believed that he could safely be bailed to his home address, as long as he was electronically monitored in order to prevent him from absconding. However, there were related child protection concerns in that his younger brother could have been put at risk if he remained at home. The situation was resolved by the YOT and court requesting that SCS undertake a risk assessment of the young person returning home, which he was then able to do.
- Wessex's Southampton team benefited from having remand foster carers: it was clear that they were selected and trained to give a consistently good service to the YOT and those referred to them, with the children and young people being matched as far as possible to their carer. This service was available to the ten to 16 age group, and there appeared to be a gap in service for 17 year olds and those with substance misuse problems.
- Blackpool used B&B accommodation for young people aged 16 and over who were bailed but did not have an address. The YOT used four or five establishments who knew the YOT and understood its requirements, but any placements were time limited to two weeks until benefits were sorted out. The premises were also open to other members of the public and consequently there was no way of the YOT checking whether the other residents posed any specific risk to the young people placed there. Blackpool also had one placement in 'approved lodgings' and a Housing Association hostel, which was staffed 24 hours a day and kept a bed available to the YOT for vulnerable homeless children and young people. Blackpool YOT recognised the need for an Arrest Referral Programme for those vulnerable children and young people either misusing substances or with mental health problems.

Good practice example:

Leeds monitored the numbers of children and young people remanded to LAA and those who found themselves in unsupported B&B accommodation due to a lack of appropriate beds. It used this information to draw up a protocol with the court outlining the level of support the YOT could provide for children and young people in B&Bs.

Criterion: ***The systems used to collect, record, verify and provide bail information to the CPS and defence solicitors is sensitive to safeguards issues.***

Completion of Bail Assets

5.12 Over the five YOTs inspected, a Bail Asset had been completed at the child's or young person's first court appearance in only 48% of cases (40 cases in total). In one case, a young person had not been subject to any type of risk assessment before they were remanded to custody. This was clearly a serious failing.

5.13 One YOT reported that it did not routinely complete Bail Assets on first appearance, but used 'recent' Core Assets if available. Although these Core Assets provided much useful, historical information on risk and vulnerability, they could not reflect the child's or young person's current situation. Furthermore, we felt that the definition of 'recent' was liable to drift.

5.14 Another YOT did not complete the Bail Asset until after the child or young person had received bail. The rationale for this was so that a 'standard' pack of BSS interventions, based on three contacts per week, could be agreed between the CPS and the YOT. The court officer would subsequently get the child's or young person's agreement to such a package, and then present a broad outline of the anticipated frequency of YOT contact to the court. The detail of the package could then be worked out between the child or young person and their bail support worker in their first meeting after court. This system did not allow for decisions on bail interventions by the court to be genuinely 'assessment led' and it ran the risk that, either a child's or young person's needs would not be met, or the court would refuse to grant bail on account of contact being deemed insufficient.

5.15 Of the completed Bail Assets, only 55% (of 22 relevant cases where there was a substantive safeguards issue) were considered to be sensitive to safeguarding and 50% (of 18 relevant cases) to diversity issues. This finding concerned us in that it suggested either that the identification of welfare and diversity issues in the Bail Asset was not a priority or that staff required further training in the completion of Asset.

5.16 Intervention plans contained in the Bail Assets were often vague, and did not address individual need. Some staff contended that this was so they could cover 'anything that comes up', whilst others commented that the format of the intervention plan in the Bail Asset did not encourage detail. One member of staff expressed concern that if the YOT wished to work on an area that was not immediately related to the child's or young person's current offence, such as cannabis use, the court might feel compelled to consider remand as an option. This suggested the need for further and more open communication to enhance the court's confidence in the ability of the YOT to address secondary risk factors.

5.17 Regarding the generally very good communication with magistrates, one set of BSS staff commented that whereas their YOT directed its awareness training at youth court magistrates, it was magistrates in the adult court, and district judges in particular, who could vary in their approach to children and young people. YOTs tended to report difficulties in ensuring that their awareness training for sentencers reached judges.

Good practice example:

- To overcome the potential difficulties inherent in children and young people arrested 'out of hours' and appearing in an adult magistrates' court, if there were magistrates working that day who were trained in youth justice the Isle of Wight court would cancel the adult court and re-convene as a youth court.
- Blackpool was seen to be using the Bail Asset well in most cases inspected. Where the Bail Asset had identified any risk or vulnerability issues, the full Risk of Harm Asset was then used and could trigger a risk management strategy meeting, which were held monthly within the YOT and attended by various managers and specialist staff.

Recording

5.18 There appeared to be a general issue around recording of information. Key contacts were frequently not recorded and remand paperwork lost. In many cases, the good work that was said to have taken place with children and young people was not evidenced in the files. Bail support and court officers reported that children and young people being on multiple, concurrent orders did not make this any easier, but acknowledged that their systems would have to meet the challenge.

Description of STANDARD 3.3:

BSS interventions take into account the safeguarding of children and young people.

5.19 **The key findings of STANDARD 3.3 are:**

- safeguard issues were taken into account in 72% of the interventions delivered as part of BSS programmes
- parent(s)/carer(s) were kept informed and involved during the delivery of their child's or young person's BSS programme in the majority of cases
- access to and provision of mental health services was problematic for several YOT areas, particularly for 16 and 17 year olds
- children and young people clearly demonstrated their understanding and agreement to BSS programmes in only 45% of cases
- the YJB's timescales for compliance needed to be adhered to more consistently.

Criterion: ***The design and delivery of BSS interventions and services take into account safeguarding issues.***

5.20 67% (of 21) of the arrangements for interventions seen and 72% (of 18) of the delivery of interventions reviewed took account of safeguards issues. This was an improvement on the proportion of Bail Assets which were assessed as being sensitive to safeguarding issues, and lent some weight to court staff's contention that time pressures and the limitations of the Bail Asset format itself, militated against a thorough assessment. However, there were obvious risks in identifying substantive safeguarding issues at the intervention rather than at the assessment stage and we did not feel that Bail Assets should be discontinued.

5.21 There was evidence of some good work undertaken by the YOTs in relation to safeguarding of children and young people during BSS.

Good practice examples:

- In Blackpool, the Bail and Risk Assets informed the programmes offered and the BSS team utilised resources from within the YOT to deliver appropriate packages.
- In Suffolk, BSS workers produced thorough and informative update reports on children's and young people's progress on BSS.
- In Oxfordshire, there was evidence of high intensity contact with children and young people outside of ISSP: in one case in particular, a BSS worker had increased her contact with an autistic young male, as he benefited from greater routine.
- Wessex had a large information pack for staff regarding BSS which contained 'contracts' for them to use with children and young people, although this had not been fully disseminated as it was not in use on the Isle of Wight.
- Leeds BSS staff made a home visit as their first appointment with children and young people as a matter of course.

5.22 There were also areas of concern. The recording of work undertaken with children and young people on BSS was often superficial. The reasons where BSS programmes were changed partway through the programme were rarely discussed with or explained to the children and young people and/or their parent(s)/carer(s). Neither was their agreement sought.

5.23 Provision of Bail ISSP places was limited. Priority was given to those children and young people already sentenced to ISSP and subject to an order such as a DTO. The ISSP provision on the Isle of Wight was hampered by the geography, in that the coordinator and project worker were based on the mainland and were only on the Island twice a week. This meant that staff spent time escorting children and young people over on the ferries, a time-consuming and expensive task.

5.24 Blackpool described problems in accessing services due to thresholds set within the mental health services. Sixteen and 17 year olds with mental health issues fell between the provision of child and adult services and only received such services if they had been in custody. Suffolk reported comparable difficulties and one area manager was particularly concerned about the intermittent nature of CAMHS appointments for children and young people diagnosed with ADHD. She stated that treatment would rarely extend beyond medication, and that there was no possibility of interventions such as behaviour modification work.

5.25 Oxfordshire had commendably addressed similar problems by contributing to the funding of a mental health team. The YOT Joint Inspection report noted that this team had recently been restructured and now provided the services of a psychiatrist, CPN and a psychologist to the core CAMHS, the local YOI and the YOT.

Criterion: ***Consideration is given to the methods likely to be most effective with the child or young person.***

5.26 In 66% of cases (of 22) consideration had been given to methods likely to be most effective. Managers described their YOTs as 'child oriented' and there was evidence of staff being the driving force behind inter-agency liaison around necessary interventions.

Case studies:

- In Blackpool, a young person had committed a number of serious violent offences and his behaviour had led to the breakdown of his family relationships. The YOT mental health worker had been working with him to address his behaviour.
- In Suffolk, there had been some excellent work to secure a good bail package for a recently remanded vulnerable young person. The BSS worker had contacted: the school, to ask about progress; the clinical psychologist, with regards to depression and risk of self-harm; and the educational psychologist to consider the best options for education. The worker also negotiated with SCS to provide support for the young person, and with Connexions, which resulted in consideration being given to the young person's difficulties with verbal and written communication.
- In Oxfordshire, the YOT asylum worker had used her strong links with the local asylum seeker centre to locate a suitable bail bed for a Romanian asylum seeker charged with theft, and had arranged the translation of all the BSS information and consent documentation into Romanian.

Good practice example:

In Suffolk, a package of support tailored to the young person's needs and interests had been provided to a young male whose offending behaviour was complicated by his gambling problem and distorted body image, the latter having led to an addiction to steroids. The YOT had good links with a voluntary organisation, which had enabled them to fund a gym pass for the young person, supervised by the voluntary organisation.

5.27 Despite examples of good practice, we had some concerns around enforcement, in that BSS workers did not always follow up missed appointments thoroughly. By not doing so, they were potentially compromising their ability to convince the court that bail was the right decision for the child or young person.

5.28 Insufficient attention was given to ensuring that the child or young person understood and demonstrated their agreement to the BSS proposed. From the file read, in only 45% of cases (of 23) had the child or young person clearly signed-up to their agreement to the package.

Criterion: ***Arrangements are in place to keep parent(s)/carer(s) informed and involved during the delivery of BSS.***

5.29 It was encouraging that in 83% of cases (of 12) there was evidence that parent(s)/carer(s) had been kept informed during delivery of BSS, from an initial contact at its inception to completion and sentence.

5.30 In Leeds, parents signed a form to confirm their consent to their child's attendance on the BSS programme. The Southampton team in Wessex reported that parental/carer contribution during the BSS programme was viewed as very important. Blackpool offered the 'Parenting Matters' intervention programme developed by Barnardos on a group or individual basis as appropriate. They also supplied leaflets to parent(s)/carer(s) as well as children and young people.

Recommendations

YOT managers should:

- *ensure that Bail Assets are completed at the child's or young person's first appearance in court*
- *improve the quality of recording of bail work in both electronic and paper case files.*

6. STANDARD 4: Pre-sentence reports

Description of STANDARD 4:1:

PSRs take into account safeguards issues.

6.1 The key findings for STANDARD 4.1 are:

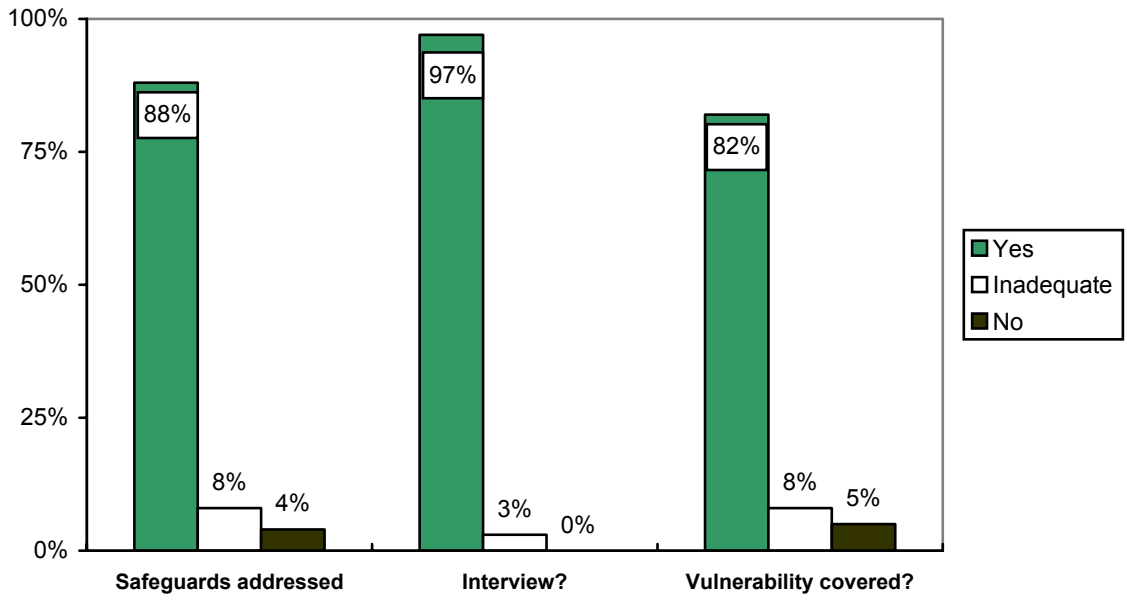
- 80% of PSRs addressed safeguarding issues appropriately and sufficiently, with a number of examples of good practice
- the possible adverse effects of custody were outlined where relevant
- issues relating to a child's or young person's gender and ethnicity were addressed in just over 50% of cases
- whether children and young people had been given sight of the PSR was rarely clarified.

Criterion: *PSRs address safeguards issues appropriately and sufficiently.*

6.2 Thirty-eight PSRs from across the five YOTs were read as part of the fieldwork. Overall, the standard in general, and in respect of safeguards in particular, was excellent. 39% of PSRs were assessed as 'excellent', 55% as 'satisfactory', with just 6% 'not satisfactory' or 'poor'.

6.3 The results from the 'Report Introduction' and 'Relevant Information about the Young Person' sections of the PSR are summarised in Figure 13.

Figure 13: Proportion of PSRs in which safeguards issues addressed, parent/carer interviewed and vulnerability covered



Commentary

- Safeguards issues in general, and vulnerability in particular, were addressed in over 80% of reports.
- Parent(s)/carer(s) were interviewed in the preparation of the report in all but one case, which was thought to be a good indictment of the significance YOTs attached to the perspective of the parent(s)/carer(s).

6.4 Whilst obviously not ideal, the figure of 80% represented continuing improvement in terms of identification of safeguarding issues, from 55% of Bail Assets through to 72% of interventions delivered as part of BSS. One reason for this improvement could be that, by the time YOTs come to write PSRs, they had more information on the child or young person on which to draw. The report writer needed to ensure that they sought out this information and reflect it appropriately in the report.

Good practice examples:

- Comments made in a report on a young woman, whose mother had died in a fire and whose father had mental health difficulties, about the impact of a curfew, saying that it could exacerbate her susceptibility to mental illness by increasing her isolation in a hostel.
- Specific mention of pregnancy as a vulnerability factor, with good cross-boundary liaison with home area's SCS with regard to the support available if young person was granted asylum.
- Good coverage of health and education issues, including emotional development and sexual identity issues in one report.
- Reports for Crown Court being discussed with managers before submission.
- One example of a quote direct from a PSR, "In my assessment X's needs are complex spanning the welfare, education and criminal justice remits and in reflection this change is likely to be a process that will take significant time".

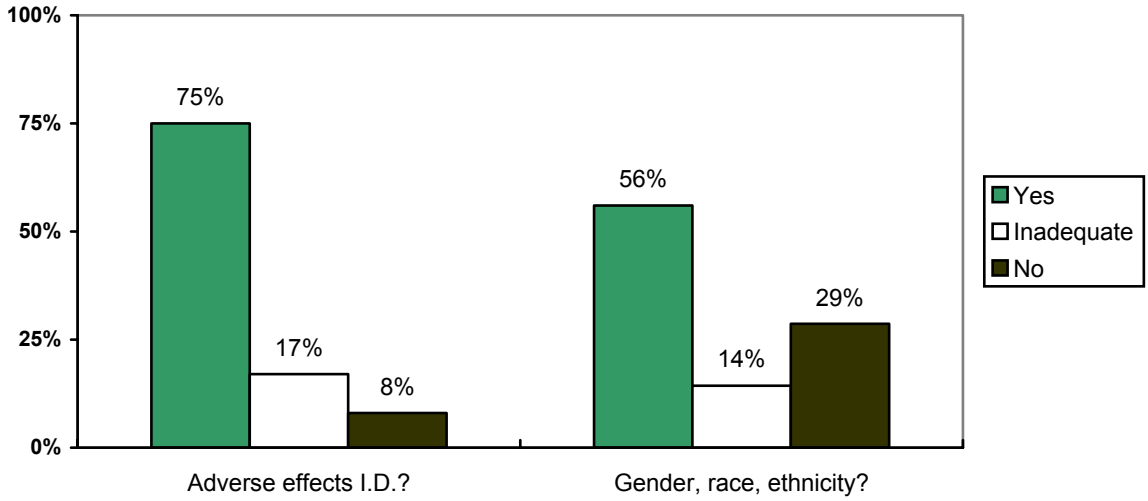
6.5 The majority of PSRs also included an informative, relevant account of the child's or young person's personal and family development, all of which was linked to offending where appropriate.

6.6 Some elements of the reports were judged inadequate. Reasons varied, but included:

- the balance of one report shifted from welfare factors being considered as a contributory factor to the young person's offending, to them being direct, causal factors
- potential benefits of parental support not being emphasised, despite being commented upon in the sources of information used in the preparation of the report.

6.7 In the case of the 'Language and Presentation' section of the PSRs, 'adverse effects of custody' and 'gender/ethnicity' were seen as the elements most directly related to safeguards, and the results of the assessment are summarised in Figure 14.

Figure 14: Proportion of PSRs in which adverse effects of custody were identified and gender and ethnicity issues addressed



Commentary

- As can be seen from column one, in 78% of PSRs authors were able to provide the courts with some persuasive and well-evidenced arguments with regard to the possible adverse effects of custodial sentences on children and young people and their families.
- Column two shows that issues relating to the individual's gender, race and/or ethnicity were adequately addressed in only 56% (of 14) cases. This was the lowest rating for any question.

6.8 A few reports were nonetheless assessed as 'inadequate' or 'poor' in this area, mainly due to the fact that report writers had neglected to outline, where relevant, possible adverse effects of custody in cases where they were making recommendations for community alternatives. There was also one case in which a report writer made a custodial recommendation for a 13 year old who had committed relatively minor assaults, "If sent to custody today I would not consider Z to be vulnerable, other than this would be his first experience of such a sentence". We had some concern around the fact that the child's age in itself appeared not to have been considered a vulnerability factor.

6.9 With regards to column two and whether PSRs adequately addressed gender, race and ethnicity, little reference was made to issues such as isolation and the fact that the language and cultural needs for black and minority ethnic children and young people, and asylum seekers in particular, might be different.

Criterion: ***PSRs are shared with children and young people to enable them to understand the content and proposals.***

6.10 Managers in different YOTs told us that PSRs were routinely shared with children and young people and their parent(s)/carer(s). However, it was not always clear from reading the reports whether this had occurred or not. Only a few reports from each YOT had

recorded that the PSR had been disclosed to the child or young person and that they had understood the proposals. Only one report referred to the relevant ruling from the Magistrates' Courts Act that children and young people should have the opportunity to read their report prior to sentencing, and this was a London YOT's PSR, supplied to one of the five YOTs as background information.

7. STANDARD 5: Remands

Description of STANDARD 5:

The assessment, monitoring and review of children and young people subject to remands address safeguards issues appropriately and sufficiently.

STANDARD 5:1:

Any LAA.

7.1 **The key findings of STANDARD 5.1 are:**

- more attention needed to be paid to the completion of the appropriate documentation
- greater clarity needed to be brought to arrangements between the YOT and SCS.

Criterion: *The completion of the appropriate forms identifies and addresses safeguards issues sufficiently.*

7.2 It was not always clear whether responsibility for completion of the LAC forms ''Essential Information' and 'Placement Plan Part 1' was located with the YOT or the SCS and, therefore not surprisingly, the issue of their completion was the subject of some contention. Some of the inspected YOTs had reached agreement with their local SCS that if the child or young person was not known to SCS, or the case had been closed for one month or more, the YOT would complete the LAC paperwork However, evidence from the file read suggested that only 63% (of 17) of LAC forms had been completed, in cases where it was the YOT's responsibility to do so. Furthermore, BSS staff in one YOT described disputes with SCS over who completed the LAC forms and the YOT having to 'push' SCS to hold reviews within 72 hours. The deputy YOT manager was optimistic that the recently updated protocol with SCS would clarify roles and responsibilities. He had also arranged a training day with SCS managers which, we felt, was a good initiative.

Good practice example:

Blackpool YOT had recently drafted a protocol for working arrangements between Blackpool Children's Services Fieldwork Team and the YOT. This was an operational interpretation of the overarching SLA between the YOT and local authority children's services, and provided useful practice guidance to practitioners.

7.3 Some YOTs reported difficulties in getting the primary carer involved in completion of the LAC forms, although there were some good examples of staff working very hard to retain parent(s)/carer(s) involvement. In one case, a YOT officer on the Isle of White had gone to considerable lengths to contact the primary carer and had then faxed the fully completed form to SCS. The officer had kept SCS informed of what they were trying to do and why.

7.4 We also considered how often the LAC paperwork, along with a copy of the Bail Asset and post-court report, was found on file for remand cases. In only 65% of cases (of 20) was sufficient information found on file, although most of this documentation addressed safeguards issues sufficiently.

7.5 In one YOT, the practice within the area was to destroy the remand documentation on sentence, without even making an entry in the case diary about the nature of the papers. In another, staff seemed only to complete post-court reports for sentenced children and young people, not remands, which we felt was unacceptable.

Description of STANDARD 5.2:

LAA with a secure requirement and Prison Service custody.

7.6 **Key findings of STANDARD 5.2 are:**

- staff followed the steps outlined in the YJB's 'Secure Facilities Placement Guidance' when requesting a placement in secure accommodation
- there was some good practice seen around secure facilities being notified of children's and young people's vulnerability
- contact between the YOT and parent(s)/carer(s) was maintained in 88% of remand cases
- more formal procedures were required to govern who takes responsibility for children and young people between being remanded to custody and being collected by the escort services
- YOT members of staff attended just over half of the remand planning meetings reviewed.

Criterion: ***A vulnerability assessment is completed on all 15 and 16 year olds whom the court is considering remanding to secure facilities, and if they are assessed as vulnerable, this is immediately communicated to the custodial establishment.***

7.7 Despite the irregular use of Bail Assets in some inspected YOTs, there was clearly some good work being done in the assessment of vulnerability, including entries on the secure facilities placement forms referring the reader to the self-harm section of an enclosed Asset assessment.

7.8 YOT remand staff in each of the five YOTs stated that they endeavoured to interview all children and young people remanded to secure facilities before they left court, ensure that their parent(s)/carer(s) were aware of the remand and assess whether there was an enhanced risk of self-harm. However, we found evidence that this had taken place in only 60% of cases. This lack of recording meant that it was not always clear who was accountable for ensuring the right checks were carried out. It also raised the question whether liaison between agencies, such as YOTs and YOIs, was sufficient to promote the safeguarding of children and young people.

Good practice example:

Oxfordshire's custody manager provided briefings to children and young people at risk of remand to custody and their parent(s)/carer(s), where they could ask questions about what their children could expect. Feedback from one family suggested that they highly valued this service.

7.9 An area of safeguarding which had been of particular concern to staff across all the YOTs inspected was the occurrence of children and young people having to spend a number of hours in the court, having been remanded to a local authority secure facility or Prison Service custody, waiting for escort staff to take them to the establishment. The escort service, be it one of the Government's contracted escort agencies or a local contractor for remands to the local authority, did not usually have jurisdiction for children and young people during this time. The YOTs' fear was that as no one agency had responsibility for the child or young person in the period between remand and collection from court, they would be required, by default, to provide the necessary oversight. This often left the YOT in the unsatisfactory position of sitting with the child or young person on the court concourse (Oxfordshire), in the YOT office until late at night (Isle of Wight) or in a room in the local police cell (Suffolk), until a placement had been found and the escort arrived.

7.10 In Leeds, one young person had escaped from his YOT supervisor and had climbed out of a toilet window in the court building and onto the roof, which he subsequently fell through and injured himself. This incident led Leeds YOT and the court to come to an agreement that magistrates would 'stand-down' the decision to remand until the escort arrived, so that children and young people would remain in the care of the courts. We thought this to be a good example of joint working to try to improve a serious situation in the absence of formal guidelines or legislation. However, district judges unfamiliar with the practice had been known to override what was only an informal, local agreement. This issue needed to be addressed.

Criterion: ***The appropriate forms are faxed to the YJB Placement Team and secure facility, and originals passed to the escort service for delivery to the establishment. Arrangements are in place to address the situation where Asset is not completed prior to custody.***

7.11 YOT remand staff interviewed were able to describe how they followed the steps outlined in the YJB's 'Secure Facilities Placement Guidance' when requesting a placement in secure accommodation. All used the yellow envelope which staff passed to the escort service for delivery to the establishment. Staff acknowledged problems with secure facilities not receiving the documentation, and it was speculated that having escort services sign for the yellow envelope might assist in making the process run more smoothly or at least be evidence that the YOT had handed the information over to the escort.

7.12 Interviews with staff at receiving establishments and escort staff were beyond the scope of this inspection, although we did speak to a member of the YOT team stationed in HM YOI Warren Hill in Suffolk. He commented that he sometimes had to chase Bail Assets and PCRs from YOTs, and in one worrying incident had been told by a London YOT that children and young people who'd been remanded didn't need PCRs and Assets.

7.13 In the few cases where there was a particular cause for concern, such as an identified risk of self-harm, evidence that a call was made by the YOT to the YJB placement team was found in only three out of seven files. The figure for calls to the secure facility was better, at six out of seven. Staff contended that these vulnerability alerts were routinely made, but that they were not always recorded. This was further evidence that better recording was required to create a clear audit trail, allowing YOTs to demonstrate that they were fulfilling their responsibilities around safeguarding.

7.14 YOTs would benefit from strengthening their links with their local probation area in order that they might be notified of any children or young people due to appear in the adult magistrates' or Crown Courts.

7.15 There were several worrying cases in which the YOT did not appear to know of the child's or young person's remand to custody until a few days after the court appearance. This was generally due to the YOT not having a presence in court (usually adult magistrates or Crown) on that day, or a lack of recording. The former situation could result in the child or young person not having any assessment made of their vulnerability and not being visited by a YOT member of staff (see criterion below).

Case study:

In one such case in Suffolk, the YOT had worked quickly to inform the YOI of the young person's circumstances as soon as they had become aware of the remand being made. They had faxed copies of the contact log and the most recent Core Asset to the establishment, highlighting key items.

Good practice example:

In Suffolk, the court officer always rang the secure training centre or YOI even if they did not have any concerns over risk of self-harm.

Criterion: ***A YOT member of staff attends the initial planning meeting and ensures that the rights and welfare of the child or young person are safeguarded.***

7.16 Safeguards issues needed to be given greater attention during the initial planning meeting. Of the inspected YOTs:

- there was evidence that a YOT member of staff attended the planning meeting in only 54% (of 13) cases
- in only 55% of cases were the specific needs of the child or young person identified
- furthermore, in just 33% of these cases was there evidence that these needs were catered for within the establishment.

7.17 Whilst the first figure could in part be put down to resources, the second suggests that either YOT staff attending planning meetings were not highlighting safeguarding issues sufficiently or, if they were, such concerns were not being recorded in the documentation.

7.18 The national standard requirement that planning meetings should take place within five working days was met in only 24% of cases. This reflected a number of factors, including the distance that children and young people were often placed from their home area and YOT. However, the standard has since been increased to 10 working days, which ought to improve compliance.

7.19 There were real advantages gained from having YOT workers based in the local YOI, some of which can be seen in the good practice box below.

Good practice examples:

- Leeds and Suffolk had the benefit of having YOT members of staff based in their local YOIs, who ensured YOT representation for children and young people and that criminal justice and safeguarding responsibilities were discharged for those remanded.
- A remand YOT worker from HM YOI Warren Hill described how he and his colleagues would try and conduct telephone conferences with the appropriate members of staff in lieu of a face-to-face planning meeting. This practice ensured that a remand plan was formulated for child or young people within the required timescale.

7.20 The Wessex Isle of Wight team faced particular difficulties in attending remand-planning meetings due to the distances involved and, as a consequence, had taken the decision to prioritise sentenced children and young people in custody.

7.21 A major difficulty reported by YOT staff in the Southern YOTs (Suffolk, Wessex and Oxfordshire) was the lack of a remand YOT presence in HM YOI Feltham, where many of their children and young people were held. This issue was also raised in the audit responses; one London YOT manager had written that, "Feltham YOI can no longer accommodate remand planning visits to remandees so there is no mechanism, other than YOT documentation, for sharing information about vulnerability issues". This issue required further examination.

7.22 In one case, an asylum seeker registered in Oxfordshire had reportedly been arrested in London and remanded to HMYOI Feltham without any YOT input. Whilst in Feltham, the young person had happened to mention the work he had done with the YOT in Oxfordshire, and Feltham prison staff were then able to contact the Oxfordshire team.

Criterion: ***A YOT member of staff ensures that the rights and welfare of children and young people are safeguarded and reviewed throughout the placement.***

7.23 This criterion was difficult to achieve for some of the YOTs inspected, given their lack of input into remands. For other YOTs, the evidence suggested that they made efforts to promote the rights and welfare of children and young people where they could. In 64% of cases, there was evidence that the YOT had worked with the secure facility to review the remand in the light of the child's or young person's progress. In 62% of cases, the YOT discussed the possibility of recommending a bail package with the child's or young person's legal advisor.

7.24 A good example of a child's or young person's progress being monitored was found on the Isle of Wight. The YOT had identified on a young person's PCR that they were at risk of self-harm and recommended that they should be closely monitored in the facility. Following a remand-planning meeting, it was learnt that the young person was being bullied and the YOT contacted the YJB to ask for an alternative placement.

Criterion: ***Arrangements are in place to keep the parent(s)/carer(s) informed and involved during the consideration of and throughout the placement.***

7.25 There was evidence of some good work in relation to this criterion. Across the inspected YOTs, the level of contact between the child or young person and their family was monitored in 88% of cases. The YOT kept the parent(s)/carer(s) informed in 82% of all cases.

Good practice example:

In Leeds, a case manager had met with the police, SCS and the young person's mother, to decide how best to deal with the risk posed by the young person to herself and to her family. It was decided that the best post-custody 'exit strategy' for the young person was for her to continue her remand with foster carers, to allow time for the YOT to help her mother develop parenting and coping skills.

Recommendations

The YJB should:

- *clarify accountability for children and young people awaiting escort, having been remanded to secure facilities or custody, and provide guidance to YOTs accordingly.*

YOT managers should:

- *with social services, clarify agency roles and responsibilities when a child or young person is remanded to the care of the local authority*
- *explore options for contributing to planning and review meetings in secure establishments where distance makes YOT staff attendance difficult, e.g. video conferencing*
- *provide training to staff to help them to identify and promote safeguards issues in secure establishments, i.e. planning and review meetings.*

Appendix 1: Results from review of existing inspection activity

A: RESPONSES TO INTERACTIVE QUESTIONNAIRE

The questionnaire data from 128 children and young people were reviewed to identify responses to those questions that had the 'best fit' with our objectives. To recap, these were:

- *to determine whether YOTs have taken into account sufficiently the safety and welfare of children and young people in their arrangements with and delivery of services to the youth court*
- *to assess whether children and young people are provided with sufficient and appropriate information about the court process in which they are involved*
- *to establish the extent to which the YOT promotes and respects the rights of children and young people throughout the judicial process between arrest and sentence*
- *to determine how effectively children and young people are safeguarded during the court process by the YOT working in cooperation with all those agencies taking part.*

Objective 4 was considered too specific to inter-agency interaction to have any reasonable correlate in the YOT specific questionnaire.

- Responses were on a four-point scale, from 'Not at all', through 'Not really' and 'Sometimes/Just about' to 'Yes always'. The latter two responses were considered a judgement of sufficiency.
- It was encouraging that children and young people were, almost exclusively, very positive about their experiences with the YOTs.[1]
- There were no questions that asked directly about Objective 1 – children's and young people's safety and welfare. However, we felt that YOT staff's ability to create a trusting relationship through good communication would be likely to increase a child's or young person's feeling of well being. In this respect, 89% of children and young people questioned said that their YOT worker 'sometimes' or 'always' talked to them in a way they could understand. An even higher percentage (94%) said they felt listened to, with an impressive 82% saying that they were 'always' listened to.
- With regards to Objective 2 – the provision of information, over 93% of respondents said that they 'just about' or 'definitely' knew why they had to work on certain aspects of their behaviour or lifestyle with the YOT. This implied that they had been provided with sufficient information on this very important aspect. 73% said that YOT staff were always helpful to them in doing this, with only one young person saying that staff were 'not at all' helpful. And only 2%

[1] It must be borne in mind, however, that YOT staff themselves administered the bulk of the questionnaires. It is therefore likely that staff administered questionnaires to children and young people that they directly supervised, and, however careful they might have been to emphasise that it was the child's or young person's true point of view that was important, it is possible that the YOT worker's presence biased the responding. Consequently, the results are indicative rather than representative.

said that 'nothing really happened' if they did not come in for appointments. The other 98% understood that there was a consequence to missing appointments, although they were not always clear exactly what this was.

- With regards to Objective 3 – promoting and respecting the rights of children and young people, 83% of respondents said that they were always treated fairly and with respect, the highest percentage seen in any one category. However, only two-thirds of respondents said that they knew how to make a complaint. This compared with the 70% of YOTs in the Safeguarding audit who stated that they had a complaints procedure. We believe these figures reinforce the need for YOTs who do not have such a procedure to create one and those that do, to ensure that it is accessible to children and young people.

B: REVIEW OF ESI DATA FROM FIRST 14 PROBATION AREAS

113 ESI 'child protection' cases where the offender was the main source of risk to the child were compared to 163 high-risk cases where there were no identifiable child protection issues. The results are described below

- Overall, there were few significant differences in the quality of offender management of child protection cases and high-risk cases. There were only two questions on which the data for the two sets of offenders differed markedly: whether sufficient pre-release work had been carried out and whether a home visit had taken place in accordance with the national standard. In the former, the child protection cases scored 54.5% and the high risk 68.6% sufficient or better, and in the latter, the child protection score was 64.8% and high risk 72.5%.
- It is possible to speculate why these differences arose. Offenders against children were likely to have been imprisoned in vulnerable prisoner units and might, therefore, have been further away from their home probation area than they otherwise would have been. This in turn might have led to fewer visits from their probation officer. However, without knowing the underlying reasons, it was difficult to assess on the significance of the different findings.

Appendix 2: Standards and criteria

Safeguarding of Young People from Arrest to Sentence
Standards and Criteria

Source Documents:

National Standards for Youth Justice, April 2000
National Standards for Youth Justice, April 2004
Key elements of effective practice: Swift Administration of Justice, YJB
Key elements of effective practice: Remand management, YJB
Remand management source document, YJB.

Context:

This inspection examines the safeguarding of children and young people from arrest to sentence. Standards for the inspection have been developed, based primarily on the sources listed above, and include the extent to which:

- the safety and welfare of children and young people are taken into account
- they are provided with sufficient and appropriate information
- their rights are promoted and respected and
- they are safeguarded effectively by YOTs working in cooperation with other agencies.

Throughout the inspection account will be taken of the child's or young person's specific and diverse needs and circumstances, e.g. race, ethnicity, gender, mental/physical health, language, etc.

Definition:

The definition of 'children's safeguards' that we use is:

all agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's and young people's welfare are minimised and

where there are concerns about children's and young people's welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies.

STANDARD 1: MANAGEMENT AND PARTNERSHIP ARANGEMENTS

Standard 1.1 – Partnerships: There is a shared understanding, evidenced in policy, between the YOT, its statutory partners and other organisations including the ACPC, about how children and young people will be safeguarded and protected.

Criteria

Information relevant to the safeguarding of children and young people is shared appropriately between agencies.

Protocols between agencies include agreed standards for practice that address the tension between data protection concerns and the sharing of information on risk.

Local policies that clarify cross-boundary arrangements with neighbouring YOTs outline clearly how children and young people will be safeguarded and protected.

Protocols between agencies promote the respect of children's and young people's rights and include effective complaints processes and access to advocacy for both children and young people and their parent(s)/carer(s).

Standard 1.2 – Leadership: The management board communicates the importance of safeguarding children and young people through its strategic oversight of, and direction provided to, the YOT.

Criteria

The management board gives guidance and support to the YOT manager, ensuring that they have clear policies, strategies and procedures to ensure the safeguarding of children and young people.

Policies, procedures and practice take full account of, and are appropriate to, the needs of children and young people with a disability or special needs.

Policies, procedures and practice take full account of, and are appropriate to, a child's or young person's unique ethnic and wider diversity needs.

Standard 1.3 – Monitoring: A focus on safeguarding results in measurable improvement in outcomes for children and young people.

Criteria

The management board ensures that the extent to which children and young people and their parent(s)/carer(s) feel satisfied with safeguarding arrangements is monitored and evaluated.

There are single agency and joint monitoring systems in place to ensure that safeguarding arrangements are robust, consistently applied and take account of diversity.

Monitoring information is used to improve safeguarding outcomes: YOTs have processes in place to identify their organisation's strengths and weaknesses and inform future practice, with evidence of changes and improvements to practice.

Standard 1.4 – Resources: Outcomes for the safeguarding of children and young people are supported by the appropriate allocation of resources.

Criterion

Policies and practice protocols address the provision of translation and interpretation services to children and young people and their parent(s)/carer(s) who communicate using British Sign Language and/or for whom English is a second language.

Standard 1.5 – Staff supervision, development and training: Staff contribute to the safeguarding of children and young people.

Criteria

Staff have appropriate skills, knowledge and understanding to safeguard the rights and welfare of children and young people.

Staff are regularly supervised in accordance with their developmental needs in relation to safeguarding issues.

Staff are appropriately qualified and have had a criminal record check.

Volunteers are appropriately trained, available for YOT activities and have been through CRB checks.

There are procedures in place to respond to both historical abuse allegations and those against staff or other non-family members.

STANDARD 2: WORK WITH CHILDREN AND YOUNG PEOPLE IN POLICE CUSTODY: APPROPRIATE ADULT AND PACE (38) 6

Standard 2.1 – Parental/carer responsibility is reinforced.

Criteria

Information on parental responsibilities is readily available at the YOT and police station.

Every effort is made to contact parent(s)/carer(s) to secure their attendance where appropriate. AAs are only used in exceptional circumstances.

Parent(s)/carer(s) are kept informed about what has happened.

Standard 2.2 – Attempts are made to achieve a suitable 'fit' between the AA and the child or young person.

Criteria

AAs are representative of the community they work in.

Consideration is given to matching the AA to the child's or young person's specific needs and circumstances.

When a request is made, the AA identifies whether or not the child or young person is known to the YOT or SCS and in what capacity.

Standard 2.3 – AA service is timely.

Criterion

AA provision is available seven days a week, 24 hours a day.

Standard 2.4 – AA contributes to the safeguarding of children and young people in police custody.

Criteria

The AA ascertains whether the welfare of the child or young person is safeguarded in the police station in accordance with PACE.

The AA promotes the child's or young person's access to, and use of, legal assistance.

There are arrangements for ensuring that children and young people get home safely.

There is satisfactory information sharing between the AA and YOT staff, on issues relevant to the safeguarding of the child or young person.

Standard 2.5 – YOT members of staff are proactive and help prevent children and young people being held unnecessarily in police custody.

Criterion

YOT members of staff are competent and knowledgeable in order to check and challenge decisions to ensure that PACE criteria are properly applied.

Standard 2.6 – Resources: Outcome for the safeguarding of children and young people in police custody are supported by the appropriate allocation of resources.

Criterion

Attempts are made to ensure that there is suitable accommodation available to meet the needs of children and young people subject to PACE transfers and/or remands to LAA.

STANDARD 3: BAIL ISSUES: BAIL INFORMATION AND BAIL SUPERVISION AND SUPPORT

Standard 3.1 – Outcomes for the safeguarding of children and young people at court are supported by the appropriate allocation of resources.

Criteria

The BSS scheme has mechanisms to ensure they are aware of and are able to deal with any children or young people appearing at youth courts, adult magistrates' courts and before a judge in chambers.

The BSS scheme is available at weekends and bank holidays as well as during weekdays.

Standard 3.2 – Assessments of children and young people on their first appearance before a court are sensitive to their specific needs and address safeguarding issues.

Criteria

The health and welfare of the child or young person is taken into account when determining the availability of an appropriate bail address.

The systems used to collect, record, verify and provide bail information to the CPS and defence solicitors is sensitive to safeguard issues.

Standard 3.3 – BSS interventions take into account the safeguarding of children and young people.

Criteria

The design and delivery of BSS interventions and services take into account safeguarding issues.

Consideration is given to the methods likely to be most effective with the child or young person.

Arrangements are in place to keep parent(s)/carer(s) informed and involved during the delivery of BSS.

STANDARD 4: PRE-SENTENCE REPORTS

Standard 4.1 – PSRs take into account safeguards issues.

Criteria

PSRs address safeguards issues appropriately and sufficiently.

PSRs are shared with children and young people to enable them to understand the content and proposals.

STANDARD 5: REMANDS: The assessment, monitoring and review of children and young people subject to remands address safeguards issues appropriately and sufficiently.

Standard 5.1 – Any local authority accommodation.

Criterion

The completion of the appropriate forms identifies and addresses safeguards issues sufficiently.

Standard 5.2 – Local authority accommodation with a secure requirement and Prison Service custody.

Criteria

A vulnerability assessment is completed on all 15 and 16 year olds whom the court is considering remanding to secure facilities, and if they are assessed as vulnerable, this is immediately communicated to the custodial institution.

The appropriate forms are faxed to the YJB Placement Team and secure facility, and originals passed to the escort service for delivery to the establishment. Arrangements are in place to address situation where Asset is not completed prior to custody.

A YOT member of staff attends the initial planning meeting and ensures that the rights and welfare of the child or young person are safeguarded.

A YOT member of staff ensures that the rights and welfare of children and young people are safeguarded and reviewed throughout the placement.

Arrangements are in place to keep the parent(s)/carer(s) informed and involved during the consideration of and throughout the placement.

Appendix 3: Safeguards thematic questionnaire

HM INSPECTORATE
OF PROBATION
SECOND FLOOR, ASHLEY HOUSE
2 MONCK STREET
LONDON SW1P 2BQ
Telephone 0207 035 2209
Fax 0207 035 2237

Dear

Joint Review of Children's Safeguards

The first joint Chief Inspectors' Review of Children's Safeguards was published in October 2002, which informed the development of the green paper "Every Child Matters" and the Children's Bill. The second review is due to report in the autumn of 2005 and a key component of this review will be the role of Youth Offending Teams in safeguarding children and young people between arrest and sentence.

As the lead inspectorate for the YOT Joint Inspections, HMI Probation will be conducting the YOT component of the Safeguard's Inspection to set standards and criteria, and this will be done in two parts:

> Part 1 – In-depth inspection of the work of five YOTs comprising analysis of advance information, examination of case files and interviews with managers and staff from the YOT
>
> Part 2 – A questionnaire to be completed by the remainder of YOTs, the results of which will be analysed and will contribute to the overall findings.

The aim of the thematic inspection is to inform learning and policy development. Therefore any conclusions drawn from it will not affect the overall score for any current or future YOT inspection.

Your YOT is to be included in Part 2 of this inspection and I should be grateful, therefore, if you could spend some time in completing the enclosed questionnaire to which there are guidance notes attached. Please return the completed questionnaire and any additional information as appropriate to: Beverley Folkes, at the HMI Probation address above, by 2nd July 2004.

Should you have any queries about the content of this letter or the thematic inspection please contact a member of the inspection team: Ben Clark on 07799 656 354 or Rose Burgess on 07771 942 675.

Thank you in advance for your cooperation in taking this stage of the inspection forward. We feel that the YOTs have made a significant contribution to the development of youth justice services, and the joint inspectorates' review team view this area of the YOTs work as critical to the safeguarding debate.

Yours sincerely,

Liz Calderbank
HM Assistant Chief Inspector of Probation

CHILDREN'S SAFEGUARDS - YOT INSPECTION

QUESTIONNAIRE FOR ALL YOTS

NAME OF YOT ……..

NAME, TITLE AND CONTACT DETAILS OF PERSON COMPLETING THIS QUESTIONNAIRE:
……
……
……

NB If there are policy, strategy, procedures or any other example of work which you assess as good practice please include copies of relevant documents with the questionnaire.

	QUESTION	OPTIONS		COMMENTS
SECTION 1 MANAGEMENT AND PARTNERSHIP ARRANGEMENTS				
1.1	Do you have specific policy, strategy and procedures addressing the role of the YOT in safeguarding children?	Yes, YOT only Yes, multi-agency Yes, both YOT and multi-agency No, but child protection issues integrated in other policies and procedures No such policies and procedures Other please comment opposite	1 2 3 4 5 6	
1.2	If the answer to 1.1 was 1,2,3 or 4: Does the policy(s), strategy and procedures cover: a) the role of the YOT in safeguarding children and young people going through a judicial process?	a) Yes No	1 2	
	b) Race, ethnicity and wider diversity issues	b) Yes No	1 2	
	c) Disability and special needs	c) Yes No	1 2	
	d) Cross-boundary issues with neighbouring YOTs	d) Yes No	1 2	
1.3	Has the management board discussed safeguarding issues in the last 12 months?	Yes, in detail Yes, but not in detail No	1 2 3	
1.4	Do you have any monitoring information about the YOT role in safeguarding in the judicial process?	Yes/No		
1.5	Is the YOT a full member of the ACPC(s)?	Yes, attend most meetings Yes but attend infrequently No	1 2 3	

1.6	How would you rate the quality of liaison on safeguards issues with: a) Police b) Social Services c) Courts d) CPS e) Defence solicitors f) Health g) Education h) Prisons Give a rating: 1=excellent; 2= good 3=poor; 4=very poor	a) b) c) d) e) f) g) h)		
1.7	Do you have any information sharing protocols with other agencies involved in youth justice?	Yes and they cover safeguards issues Yes but they do not cover safeguards issues No		1 2 3
1.8	Do you have a complaints procedure for children and young people in judicial proceedings?	Yes No		1 2
1.9	Do you have arrangements in place to elicit feedback covering safeguards issues from parent(s)/carer(s)/children/young people?	Yes from all Yes from parent(s)/carer(s) only Yes from children/young people only No		
1.10	Is there sufficient accommodation available for children and young people subject to PACE transfers and/or remands to local authority or secure accommodation?	Please describe		
1.11	Have all of the YOT staff who have contact with children/young people been through CRB checks?	All Most None Not sure		1 2 3 4
1.12	If you contract out any services do you ensure that contract staff who have contact with children/young people have gone through relevant CRB checks?	Yes No Not sure		1 2 3
1.13	What training/development have YOT staff had in the last two years that addresses safeguards issues?	Please describe – numbers and designations of staff and a brief description of training undertaken		
1.14	Do you have policy, strategy and or procedures covering safeguards in relation to: a) AA Services b) Bail Information c) Bail Support/Supervision d) PSRs e) Remands to local authority and secure accommodation	a) b) c) d) e)	Yes/No Yes/No Yes/No Yes/No Yes/No	
1.15	If there are specific areas where you would like to see improvements, local or national, please describe opposite.			
1.16	If you have any examples of good practice please describe here.			

Thank you for completing this questionnaire.

GUIDANCE NOTES

General

- The definition of 'children's safeguards' that we use is:

  all agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's and young people's welfare are minimised and;

  where there are concerns about children's and young people's welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies.

- Please use the comments column to draw our attention to specific issues particularly where you want to show that the YOT is meeting a standard/criterion.
- If you find that none of the options fits please feel free to include other comments under the comments column.

Notes on Specific Questions

1.4 We would be particularly interested if you have collected any feedback from children/young people about their experience of having their health/welfare safeguarded.

1.6 We are interested here in your opinion about the extent to which different agencies are engaging with the YOT in the safeguarding agenda.

1.10 Here and in section 3 we refer to section 38(6) of the Police and Criminal Evidence Act 1984 which was amended by the Powers of Criminal Courts Act 2000. It set out the responsibilities of the custody officers in police stations where children/young people are detained. We are interested in the extent to which AAs and other YOT staff are knowledgeable about this legislation and feel able to challenge where appropriate.

1.11 It would be helpful here to specify the extent of the routine checks that are made.

1.13 Examples of training might include ACPC child protection training, relevant risk assessment and risk management training but only where it covers safeguards adequately.

1.16 We are particularly interested to hear about good practice. This could be policy or procedures, a good example of practice, etc.