



SAFEGUARDING CHILDREN

*THE NATIONAL PROBATION SERVICE ROLE IN
THE ASSESSMENT AND MANAGEMENT OF
CHILD PROTECTION ISSUES*

2002

FOREWORD

This report concerns the specific role of the National Probation Service in the assessment and management of child protection issues and is from HMIP alone. It follows previous joint Inspectorate reports to emerge from the review of arrangements to safeguard children.

This report is timely and necessary. The formation of the National Probation Service in April 2001 and other structural changes – the creation of autonomous Youth Offending Teams earlier and the Children and Family Court Advisory and Support Service at the same time – have had a profound impact on the shape of the service. Probation staff no longer have routine contact with, or are well prepared for dealing with children. Given the changes to the probation officer training curriculum, there is a danger that the pool of relevant knowledge and experience of working with children may decrease to the point that the service is insufficiently alert to the issues for which it remains responsible.

The National Probation Service continues to have an important role to play in the multi-agency framework established for safeguarding children. Staff have a statutory duty to supervise offenders who may present a risk of harm to, or may have regular contact with children considered to be at risk.

The report contains many reassuring findings. Staff interviewed understood and were committed to the principles of safeguarding children. All the probation areas in which fieldwork was conducted either provided, or had access to child protection-related training for relevant staff. Further, the multi-Inspectorate team found many examples of individual good practice. Nevertheless at a national level, across agencies, safeguarding children was not being given a clear strategic policy focus or priority. There was, in consequence, a lack of clarity at a local level. This finding is consistent with this Inspectorate's previous reports, which found that public protection issues generally needed to be accorded a higher strategic policy priority.

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The other six Inspectorates – the Commission for Health Improvement, and the Inspectorates for Police, Prisons, Crown Prosecution Service, Magistrates' Courts Service and the Office for Standards in Education also played a significant part in the design and implementation of this inspection.

Seven probation areas (London, Nottinghamshire, Kent, Surrey, North Yorkshire, West Mercia and Greater Manchester) and the National Probation Directorate were involved in the fieldwork. Without exception they participated with a commitment to improving policy and practice and ensuring that inspection activities ran smoothly. In addition, thanks go to the 40 probation areas that responded to a national survey on child protection work and Multi-Agency Public Protection Panels.

Andrew Bridges carried out the fieldwork in four of the eight Area Child Protection Committee areas and, in addition, Christine Fiddes and John Hutchings assisted with the fieldwork in one area. Behind the scenes a great deal of work was done by HM Inspectorate of Probation's administrative and information staff.

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GLOSSARY OF TERMS

Risk of serious harm is generally defined as a risk which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

Safeguarding is a term used widely but it has been rarely defined. The inter-agency inspection took the term to mean:

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

This definition takes into account the role of the National Probation Service in working with potentially dangerous offenders who present a risk of serious harm to children.

Child protection is used to describe the work done by many agencies to ensure the safety of specific children. In the probation context, this would typically involve the supervision of an offender, who may not necessarily be the main source of risk but is in contact with a child considered at risk of significant harm and who may be on the local Area Child Protection Committee Register.

Registers are locally held lists of offenders considered likely to present a high risk of serious harm to the public. Many probation areas also keep a separate register of those cases where there are child protection concerns. These always contain cases where a child is registered on the Area Child Protection Committee Register but may also contain cases where, although not registered, there are safeguarding concerns. One case may appear on both types of register.

The Assessment Framework is the assessment tool administered by social services social workers in cases where specific children are thought to be in need of services or at risk of significant harm. The Assessment Framework is set out in *Working Together to Safeguard Children*.¹

Section 47 Inquiries – social services have a duty to carry out an inquiry under Section 47 of the Children Act 1989 if they have reason to believe that a child is suffering or is likely to suffer significant harm.

OASys is a comprehensive risk/needs offender assessment tool that has been jointly developed by the prison and probation services. It is in use in some probation areas and is being rolled out nationally.

Potentially dangerous people are defined as offenders, and also unconvicted people, who present a high risk of harm to the public, including children.

¹ Department of Health, Home Office and Department for Education and Employment *Working Together to Safeguard Children* A guide to inter-agency working to safeguard and promote the welfare of children (1999).

INTRODUCTION

The Inspection

The Social Services White Paper *Modernising Social Services*, published in 1998,² proposed that all Chief Inspectors of services substantially involved with children should publish a single joint report on children's safeguards. This was to enable the Government to satisfy itself that the safeguards for children were being properly implemented and that their safety continued to be given the priority it deserved. The Chief Inspectors of the Social Services Inspectorate (SSI), the Office for Standards in Education (OFSTED), the Commission for Health Improvement and the Inspectorates for Prisons, Probation, Police, Magistrates' Courts Service and the Crown Prosecution Service (CPS) made a joint commitment to take this work forward by reporting every three years commencing in 2002.

The full inspection³ evaluated the:

- implementation of *Working Together to Safeguard Children* and the Assessment Framework
- extent to which local Area Child Protection Committees (ACPCs) had fully and effectively addressed the full range of their duties and responsibilities
- initial working of arrangements for the protection of the public, and children in particular, from dangerous people.

A set of standards and criteria was developed specifically for the full inspection. Standards 1 to 7 (see Appendix 1) were based on the *Working Together Guidance* and Standard 8 on the *Initial Guidance*⁴ on Sections 67 and 68 of the Criminal Justice and Court Services Act 2000. The latter is reported on in a separate joint report from the probation and police Inspectorates.⁵

HM Inspectorate of Probation (HMIP) decided to take the opportunity provided by the full inspection to also assess the specific role played by the National Probation Service (NPS) in relation to the assessment and management of child protection issues based on Standards 1 to 7.

Methodology

The methods used during the full inspection were developed and agreed jointly. Some of the activity was carried out by individual Inspectorates and other work involved collaboration between two or more Inspectorates. The SSI chose eight local authority areas for the fieldwork (see Appendix 3 for details). The fieldwork took place between December 2001 and March 2002.

² Department of Health *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards* (1998).

³ Department of Health *Safeguarding Children A joint Chief Inspectors' Report on Arrangements to Safeguard Children* (2002).

⁴ Home Office *Initial Guidance to the Police and Probation Services on Sections 67 & 68 of the Criminal Justice and Court Services Act 2000* (March 2001).

⁵ HM Inspectorate of Constabulary/HM Inspectorate of Probation – *Protecting children from potentially dangerous people Inter-Agency Inspection on Children's Safeguards* (2002).

The inspection involved initial and fieldwork phases, the collation of the evidence and feedback to each one of the agencies:

- **initial pre-inspection activity** included scrutiny by HMIP of relevant NPS data and documentation, a questionnaire to probation areas, file reading and a joint Inspectorate meeting to share initial findings
- **fieldwork** was undertaken in a modular way, so that each of the Inspectorates joined the inspection for specified days. The probation fieldwork took place on one day and probation inspectors were assisted by an inspector from the SSI
- **the collation phase** involved extensive discussion amongst the eight Inspectorates pulling out the common themes and emerging findings against each of the criterion.

The methodology included:

- **scrutiny of policy and other relevant documents** – national and local probation service statements covering the promotion of the safety of children, effectiveness of inter-agency working to safeguard children and communication with local communities
- **national survey of policy and practice** – questionnaires covering child protection and public protection issues were sent to 42 probation areas. Forty were returned
- **file reading** – two samples of probation case records were scrutinised using a specially designed inspection tool – the sample commented on in this report was 54 probation case records involving child protection concerns
- a wide range of interviews with the Director of the NPS and members of the Home Office Dangerous Offenders Unit. In each area interviews with the Chief Officer, Board Chair, senior manager(s) with strategic responsibility for public protection, human resource management and training, local team or district managers and practitioners
- a scrutiny of recent HMIP Thematic and Performance Inspection Programme (PIP) reports – focusing on the findings in relation to child protection issues.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The focus of the full inspection was on the arrangements to safeguard children overseen by ACPCs and Multi-Agency Public Protection Panels (MAPPPs). Eight Inspectorates worked together to inspect in eight ACPC areas against an agreed set of standards and criteria. The full inspection aimed to evaluate the:

- implementation of *Working Together to Safeguard Children*⁶ and the Assessment Framework
- extent to which local ACPCs have fully and effectively addressed the full range of their duties and responsibilities
- initial working of arrangements for the protection of the public, and children in particular, from dangerous people.

This report examines the NPS role in the first two of these.

Summary of findings

Strengths

- Nearly every area in the country had a policy covering child protection.
- The NPS, in collaboration with the prison service, was introducing a national offender assessment tool (OASys) which included a detailed section on risks to children.
- All the staff interviewed understood the importance of, and were committed to the protection of children.
- Probation areas had provided or had access to basic child protection-related training for relevant staff.
- There were good systems in place for safeguarding checks of new employees.
- All areas provided regular supervision and appraisal for staff.
- Attendance at ACPCs by probation representatives was good and at an appropriate grade.
- In a majority of cases probation staff showed an alertness to the welfare of children.
- Some recording of contacts with other agencies and action taken by probation staff was done well.
- Liaison by most other agencies with the NPS was good.
- Most areas had good access to interpreters and were developing specific support services for working with refugees and asylum seekers.

Areas for improvement

Policy, strategy and staffing

- Safeguarding children was not given a clear strategic focus and priority within public protection frameworks both nationally and locally.
- There were insufficient national links with key agencies involved in safeguarding children.
- Not enough use was being made of local strategic planning frameworks.
- Diversity issues were not well integrated into public protection policy and strategy.

⁶ Ibid, see footnote 1.

- Safeguarding responsibilities were not always made clear in contracts with relevant partners.
- Performance monitoring requirements in relation to child protection cases were poorly defined.
- Children's safeguards issues did not have a specific focus in the monitoring, review and evaluation of high risk of harm cases.
- Minimum expectations of the skills, knowledge and experience required to supervise and exercise line management oversight of cases with child protection concerns were unclear and not taken into account in the allocation of some cases.
- Safeguarding checks and arrangements for children as visitors in offices were in need of review.
- There were few arrangements for the dissemination of lessons learnt from research and experience about safeguarding children.

Probation service role on ACPCs

- There were no formal links established between ACPCs and MAPPs.
- Staff lacked confidence about the legislative framework covering the sharing of information.
- The role of probation representatives on ACPCs, including their delegated authority, was unclear.
- Financial and other contributions to ACPCs were inconsistent.

Identification, registration and assessment of cases

- Identification of cases as having child protection concerns was poor.
- The system for the registration of child protection cases by areas was unclear.
- The assessment of the risk of serious harm to children, including the understanding of the Assessment Framework, needed improving.
- Understanding of the risks to children from domestic violence was inconsistent.

Case and risk management

- The case recording of child protection issues, including the location in the file of confidential and third party information, needed improving.
- There was insufficient coverage of child protection concerns in supervision plans.
- Cases did not always comply with national standards.
- Practitioners found it difficult to integrate consideration of diversity issues into their public protection practice.
- Areas could not be sure that interpreters used for child protection cases were suitably experienced.
- There was a lack of clarity about the expectations for line and senior management oversight of cases with child protection concerns.
- The quality and timeliness of risk management plans needed improving.
- Appropriate links were not being made between serious incident reviews and Chapter 8 reviews both in practice and in policy.

Recommendations

These recommendations should be cross-referenced to those in the main *Safeguarding Children* report and the separate report *Protecting Children from Potentially Dangerous People* (see Appendices 5 and 6).

In relation to policy and strategy, the Director of the NPS should ensure that:

- there is a clear focus and priority given to children's safeguards as part of the development of public protection policy and strategy, supported by appropriate targets and performance monitoring
- diversity issues are integrated into public protection policies and strategies
- minimum expectations for knowledge, skills and experience are established for staff supervising cases with child protection concerns
- lessons learnt from research and experience are evaluated and disseminated.

In relation to the NPS role on ACPCs, the Director should, in consultation with other relevant agencies:

- review the role of probation representatives on ACPCs with a view to clarifying their responsibilities
- consider the introduction of a national formula for funding ACPCs to ensure consistency of approach
- establish formal links between MAPPPs and ACPCs
- improve the understanding of the legislation and protocols governing information sharing.

In relation to probation practice, the Director of the NPS should improve:

- the system for the identification and registration of cases with child protection concerns
- probation assessment of the risk of serious harm to children
- the integration of diversity issues into public protection practice
- the quality of supervision plans
- compliance with national standards for contact and enforcement
- case records and recording, including provision for third party and confidential information
- the oversight required in child protection cases by line and senior managers.

BACKGROUND

1. The Children Act 1989 gave local authorities and other public bodies a duty to provide support and services for children in need, and to inquire into cases where there was reasonable cause to suspect a child was suffering or was likely to suffer significant harm.
2. *Working Together to Safeguard Children* was issued in 1999 providing new guidance on these duties. It emphasised that promoting children's well-being and safeguarding depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals. The guidance sets out in detail the roles and responsibilities of each agency. For the NPS, the role in safeguarding children arises out of its statutory duty to supervise offenders who may be a source of risk of harm to children or may have regular contact with children who are considered to be at risk. *Working Together Guidance* describes some of the roles played by probation staff during the course of their contact with an offender, including:
 - assessing a case for child protection concerns
 - liaising with other agencies in order to contribute to ensuring the safety of the children involved
 - devising and implementing risk management action plans.

Although NPS staff do not have a statutory responsibility to provide support and services to children in need, they have an important contribution to make managing and reducing the risk of harm presented by the offenders they supervise. In a significant number of cases it will be a probation practitioner who identifies the risks and alerts other key agencies of the need for intervention. It is crucial that relevant probation practitioners have the knowledge and skills to be able to carry out these responsibilities well.

3. The NPS is included in the list of core representatives on ACPCs (see Appendix 2). The committee is an inter-agency forum for agreeing how different services and professional groups should cooperate to safeguard children in their area and for making sure that arrangements work effectively to bring about good outcomes for children. One of the main tasks of ACPCs is to establish arrangements to meet the relevant training needs of practitioners from all agencies, normally delivered in an inter-agency context.
4. In addition, HMIP expected that the NPS would ensure the following:
 - the inclusion of children's safeguards issues in relevant policies and practice guidelines
 - the safety of children visiting probation premises
 - safeguarding checks as part of the recruitment and selection of staff
 - active participation in relevant Chapter 8 case reviews⁷ and dissemination of the lessons learnt.

⁷ Chapter 8 of *Working Together to Safeguard Children* sets out the requirements to review cases where a child dies and abuse or neglect are known or suspected to be a factor. They are also known as 'Part 8 reviews'.

FINDINGS

Policy and strategy

National policy and strategy

5. In recent years the NPS focus on child protection had been subsumed under the development of local public protection policy and strategy initiatives. In fact it had been many years since the last national probation circular addressing child protection policy and practice specifically was issued. At the time of the inspection there was no manager in the National Probation Directorate (NPD) with specific responsibility for child protection policy and practice. The National Director acknowledged that the NPS had inherited this strategic gap and that other priorities had taken precedence in its first year of operation. There were no relevant performance indicators and the issue will only be addressed by 2004 when a target covering serious incidents, that should include child protection concerns, comes into effect.
6. Safeguarding children did not have a specific focus within the national public protection agenda and steps needed to be taken to ensure that policy, strategy and performance targets reflected this. The absence of a national focus on child protection issues had led to an inconsistent approach in areas, e.g. the absence of an agreed formula for the probation financial and professional contribution to ACPCs. This is covered by a recommendation on priorities for all relevant agencies in the national inter-agency report (see Appendix 5).
7. Although there was evidence of inter-agency communication and cooperation at a local level, facilitated by ACPCs, there was no equivalent at a national strategic level involving the NPS. The development of a coordinated inter-agency approach to the recommendations in the national inter-agency inspection report will be critical to addressing the deficits identified.
8. There were some national developments which had the potential to improve the strategic focus on children's safeguards, e.g. the introduction of the OASys which provides the opportunity for improving coverage of child protection concerns.

Area policy and strategy

9. In HMIP's national survey, 12 out of the 40 probation areas responding had a probation-only child protection policy, ten had a multi-agency policy, nine had both and seven included child protection issues in their public protection policy. Only one area reported not having any such policies.
10. The absence of a national lead on safeguarding children clearly had an effect on the importance accorded to the development of policy and practice in local areas. In most areas it had been some time since the quality of practice had been looked at in detail. Although there was a commitment to safeguarding in theory, in practice this was not demonstrated in the priority given to this work. This was highlighted in *Safeguarding Children*, the joint Chief Inspectors' Report, as an issue for many agencies.

11. Many areas stated that their child protection policies were in need of updating or they were in the process of doing it. Public protection policies and practice guidelines had been updated in many areas prompted by the new requirement to agree Multi-Agency Public Protection Arrangements (MAPPA) as a result of the Criminal Justice and Court Services Act 2000. However, there still needed to be a clearer focus on the specific needs of children within these developments.
12. There was little evidence of effective integration of local planning mechanisms, e.g. Children's Services Plans, being taken into account in the development of probation public protection strategies. Many managers thought that this was too difficult to achieve given the number of stakeholders involved and the limited time periods available for consultation. Inspectors were of the view that more effective use could have been made of the existing planning mechanisms, e.g. crime and disorder partnerships.
13. One of the obstacles to integrating planning mechanisms was the lack of co-terminosity of boundaries between agencies. While police and probation had the same boundaries as a result of the restructuring of the probation service in 2001, other agencies operated on sometimes very different geographical patches. One probation area might have to liaise with several social services departments, health organisations, housing departments, etc. In larger areas this was seen as a significant barrier to cooperation, again not assisted by the absence of national protocols to facilitate liaison arrangements.
14. The addressing of diversity issues within public protection policies was assessed by inspectors as generally weak. Staff and managers appeared to have difficulty in integrating consideration of diversity into their thinking about public protection. This was compounded by the problem in some areas of inadequate monitoring of diversity issues.
15. Where services relevant to offenders were being delivered on behalf of the probation area by a commissioned partner, some but not all areas had ensured that safeguarding matters were clear in the partnership contracts, e.g. specifying the need for police checks for staff delivering services on probation premises.

Performance monitoring and evaluation

16. There was no national performance monitoring gathered or published specific to children's safeguards. However, there was similarly no national monitoring of public protection cases assessed as posing a high risk of harm. Most areas were collecting information about child protection cases, e.g. the number held on the probation child protection register, but there was no common data specification. With the national introduction of OASys this may improve if well implemented and effective use is made of the available data, but it requires a national lead on the information requirements for this area of work.
17. Four out of the seven areas visited had carried out a periodic audit of high-risk cases as part of their public protection work. These may have included child protection cases but there was no specific focus. The Nottinghamshire Probation Area carried out an annual audit of child protection cases which normally led to an improvement action plan. This was good practice.

Staffing issues

18. On appointment most staff should be subject to safeguarding checks for previous convictions before taking up their posts. Every probation area inspected reported that they had a robust system for carrying out these checks. In some areas staff were allowed to start work before the checks were completed. Although most probation staff would very rarely have unsupervised access to children, this practice should stop unless a proper risk assessment has been done and it is clear that there is no risk involved. More care should be taken with staff whose roles involved, for instance, visiting offenders or victims at home.
19. The new Criminal Records Bureau was not in operation at the time of the inspection, but a national decision had been made to register the NPS as needing the lowest level of detail involved in checking. There may be some probation service roles, e.g. victim inquiry officers, where this would be insufficient and inspectors considered that this decision should be reviewed to ensure its suitability for the range of roles undertaken by probation staff.
20. Although checks were made upon appointment to the probation area these were rarely updated. In some areas administrative staff were excluded from the police checks. Whilst it was clear that many of these staff would have no contact with children, there had not been a thorough review of the roles of all staff to establish their likely contact. During one visit to a probation office it was found that children had been allowed to wait in a probation waiting area where any staff could have had direct unsupervised access, as could offenders also using the waiting room. On this issue probation areas should ensure that they have clear policies on ensuring the safety of children visiting probation premises.
21. All the staff interviewed clearly understood the importance of, and were committed to the protection of children. This was also evident in most of the case files read. However, given the recent absence of a focus nationally and locally on safeguarding issues, it was not surprising that many managers and practitioners lacked a clear understanding of their roles, had received little recent relevant training and were unsure about current policy and practice guidelines. The culture of vigilance was affected adversely by fluctuating staffing levels and competing priorities.⁸ Managers and practitioners in areas that had been affected by high turnover and difficulty in recruiting suitably qualified staff expressed concern about their ability to devote sufficient time to the supervision of cases involving child protection concerns. Areas were appropriately being given clear priorities by the NPD, e.g. enforcement and the implementation of accredited programmes. However, this was affecting the supervision of cases involving child protection concerns, as the priority to be afforded to public protection, including child protection, had not been sufficiently clear. Recently issued NPS guidance on workload priorities had included safeguarding children as paramount. This was a positive indication of priority being given to this agenda.
22. In most areas there was an expectation that all relevant staff would undergo a basic training package offered by ACPCs, although this was rarely a mandatory requirement before taking on cases with child protection issues. It would have been better practice to ensure that, before undertaking the supervision of cases with child protection concerns, practitioners had completed basic training and were sufficiently experienced. There were some examples of trainee probation officers (POs) and probation service

⁸ This was covered in *Safeguarding Children* see footnote 3.

officers (PSOs) taking responsibility for cases. It was appropriate for them to be involved but the cases should have been the primary responsibility of a suitably qualified and experienced practitioner. Although inspectors met many suitably experienced and skilled line managers with responsibility for oversight of child protection cases, there were also managers who had had insufficient experience and training or whose knowledge and skills had not been updated.

23. In some areas where inspectors assessed the ACPCs to be well resourced and effective, ACPC-led training programme staff had received more relevant and recent training. However, recruitment problems and high sickness rates affected attendance at training courses even where they were available. Many areas needed to improve their links between the ACPC training coordinator (where there was one) and their own training managers. There appeared to be a direct relationship between the take-up and the extent to which the ACPC programme was seen as addressing the learning and development needs of probation staff. There was a role for probation managers to ensure that training programmes met the needs of probation staff. Although most areas included a focus on child protection in their annual training plan, this was not against a backdrop of a sufficient needs analysis.
24. There were examples of good practice in training:
 - North Yorkshire had included a module on child protection as part of its core induction for staff
 - Surrey had a well-managed system for tracking who should and did attend relevant training and also sought feedback on the impact of training after three months
 - Kent had a well-established system for evaluating the impact and quality of training
 - In addition, Kent had an impressive range of training available to staff, e.g. courses on the Assessment Framework, attendance at case conferences, child protection in domestic violence contexts, basic child protection and the connection between drug misuse and child neglect.
25. Although many staff had undergone basic training on child protection this was not routinely updated. It was of concern that many were unaware of the new Assessment Framework introduced with the implementation of the *Working Together Guidance* from 1999 onwards. For those working directly with cases involving child protection issues, it is essential that they keep up to date with current practice. Few areas were able to identify who had completed relevant training and which staff needed it. Sometimes this related to the training being free at the point of delivery and therefore not being included in the monitoring systems for training departments. Minimum expectations for training is covered by a recommendation in *Safeguarding Children, A joint Chief Inspectors' Report* (see Appendix 5).
26. Most areas had included a section on staff safety in their public protection policy but, in some areas, this was not well implemented, e.g. in one area a public protection policy had come into effect before staff had been properly briefed and they were not aware of the new provision for assessing risk to staff.

27. There was no coordinated national system for disseminating the lessons learnt from research and experience. Only a few examples of good practice were demonstrated in local areas – in North Yorkshire, the library identified and disseminated national and local research; in Kent, a forensic psychologist was employed to deliver training and included current research in the programme.

Information sharing

28. All areas inspected had an inter-agency protocol developed jointly by the police and probation services covering public protection as part of MAPPA. However, few areas had an inter-agency protocol focusing on information sharing in the child protection context, including the links between MAPPPs and ACPCs. There was no national guidance on the subject. The full inter-agency inspection found that many staff from all agencies were confused about their responsibilities and duties to share information about child welfare concerns with other agencies, and were not confident on what basis other agencies shared information with them. Many probation staff lacked confidence about their legal position.
29. There was little in the way of guidance to help practitioners maintain the balance between protecting the welfare and safety of children and the rights of the individual as covered by recent legislation. The file reading events and meetings with staff indicated that decisions were clearly in favour of children. However, probation staff needed to be more confident that they were acting within the legislation, e.g. in framing licence conditions for offenders' early release from prison, but practitioners often faced a dilemma concerning protecting a vulnerable victim and not infringing the offender's civil rights with draconian measures.
30. No examples of information sharing practice had been monitored, reviewed or evaluated. Assumptions were being made that all information shared was relevant and proportionate. Information sharing between agencies should be a focus in the routine monitoring of cases.

ACPCs – The probation role

Distribution of ACPCs

31. ACPCs are inter-agency fora for agreeing how the different services and professional groups should cooperate to safeguard children in their area and for making sure that arrangements work effectively to bring about good outcomes for children. The *Working Together Guidance* on ACPCs established the NPS as a core member together with social services, education, health and the police (see Appendix 2).

Table 1, based on HMIP's national survey, shows the distribution of ACPCs in the 40 probation areas that responded.

Table 1 ACPCs – Distribution

<i>Number of ACPCs</i>	<i>Number of probation areas</i>
1	9
2	10
3	6
4	6
5	3
6	2
7	1
9	1
10	1
32	1

Commentary

- There are 42 probation areas and many more local authorities. This meant that some probation areas had to participate in more than one ACPC, e.g. in London there are 32 ACPCs.
- In areas with more than one ACPC there were also other district-based groups such as MAPPPs, drug action teams and crime and disorder partnerships which needed probation representation. In this inspection some areas described this as burdensome. Managers expressed their concern that keeping up representation for all the relevant fora was difficult, particularly in small areas and those with a number of local authorities to liaise with.

ACPC attendance and resources

32. Twenty-eight probation areas (70%) reported that they gave a high priority to attending the ACPC, with 11 giving it medium priority and one area a low priority. 80% sent a senior manager, normally an assistant chief officer (ACO). In the areas visited for the fieldwork all sent a representative to ACPCs and regularity of attendance was assessed as good.
33. In most areas inspected there was appropriate probation representation on the ACPC. Where attendance was delegated below senior management, probation areas did not always ensure that the representative had sufficient delegated powers, e.g. to agree the annual probation budget contribution.
34. Some of the probation managers attending the ACPCs saw their presence as marginal to the agendas under discussion. A number said that they struggled to see what role they could play other than to respond to specific probation related issues, which were raised infrequently. Many of the ACPC representatives also played an active role in MAPPA but they had not created an active link between the ACPC and the MAPPP. This is covered by a recommendation in *Safeguarding Children*, A joint Chief Inspectors’ Report (see Appendix 5).
35. Table 2 sets out the financial contribution made by probation areas to ACPCs.

Table 2 Probation contribution to ACPCs	
ACPC	Financial contribution for 2001/2002
Hammersmith and Fulham	£1,000 (9.5%)
Harrow	£250 (2.5%)
Kent	£3,315 (2.5%)
Surrey	£3,000 approx (2%)
Nottingham City	£1,500 (1%)
North Yorkshire	£1,300 (4%)
Shropshire	£1,800 (15%)
Stockport	£1,100 (N/A)

Commentary

- Contributions were normally used to fund a joint training programme or Chapter 8 reviews and, in one area, extended to an ACPC coordinator and administrative staff.
 - The budgets of ACPCs varied considerably, as did the probation contribution. The full inspection found that better funded ACPCs were generally more effective.
 - It would have been helpful if there had been a national formula for funding ACPCs, determined both by size of area and differential funding from the different organisations. There was a wide variation in the proportion of the ACPC budget being contributed by probation areas, ranging from 1% to 15%. Most areas reported making a contribution 'in kind' by providing probation input into joint training events. This also made it difficult to determine the precise overall contribution being made.
36. Probation representatives as core members had a responsibility for the effectiveness of the ACPC. It was of concern that although they were sometimes critical of the effectiveness of the ACPC, having positioned themselves, or being seen by others as on the margins, they tended not to take an active role in trying to improve it.

Identification, assessment and registration

Identification of cases with Children's Safeguards concerns

37. NPS staff have responsibility for managing a wide variety of work that has the potential to raise issues about safeguarding children. This includes:
- assessing and supervising offenders who are considered to present a risk of harm to children
 - assessing and supervising offenders who have day-to-day contact with children who are thought to be at risk of significant harm
 - providing information to victims of serious sexual or violent offences who may be children.
38. In all of these cases it is important for children's safeguards concerns to be properly identified and addressed. This report focuses on cases in the second category where the offender may or may not be the main source of risk to children. Of the 52 cases in the file reading, 42 (81%) of the offenders were considered to be the main risk to children. The file reading contained 16 cases where there were children on the ACPC child protection register, 26 cases where they were not and two cases where this was not clear. File readers were asked to describe the nature of the risk to children. An

analysis of the sample showed that violence and neglect were the most common risks of harm to children in probation managed cases (see Appendix 4 for details).

39. Some cases involved more than one type of concern. File readers were asked to give a brief narrative description of the nature of the risk. Some of these were:
- “She is a young mother working as a prostitute and using drugs during the pregnancy. He is a drug user and has a history of violence.”
 - “The offender had a previous conviction for grievous bodily harm (GBH) against his daughter.”
 - “Children were at the centre of a hostile domestic violence situation. Adults unable to put the children first and offender had a previous conviction for assault on a stepchild.”
 - “At risk of neglect – mother went away on holiday and left the children.”
 - “Sexual abuse to children by a close family member.”
 - “Emotional abuse and neglect. Concerns are mother’s alcohol abuse, violent nature of relationship with partner and poor parenting skills.”
40. The file reading showed that about a third of cases identified child protection concerns at an early stage in the court process, a further 22% at the pre-sentence report (PSR) stage and then the rest during supervision. In 83% of cases identification of the child protection issues was prompt, in four cases it was not and in five cases it was not clear from the record.
41. There was a particular need to improve the risk of harm to children in domestic violence cases. There were some examples of good practice, e.g. the PO who, after an interview with the offender, contacted the police alerting them of a possible threat to the offender’s partner. However, there were a number of examples of the presence of children during a domestic violence incident not being recorded nor the risk properly addressed. One example of good practice was an ACPC that offered specific training opportunities on protecting children in the context of domestic violence.
42. A common discussion during the file reading events and the fieldwork related to the positioning of thresholds for referral of a case with child protection concerns to social services or the police. It was clear from the full inter-agency inspection that there was a lack of common understanding about where thresholds lay. A few probation staff gave examples of referring cases to social services where views differed between the agencies on whether some sort of intervention should be made. This issue is covered in a recommendation to the Department of Health in *Safeguarding Children*, A joint Chief Inspectors’ Report.

Assessment of child protection cases

43. At whatever stage an offender comes into contact with the probation area, an assessment of risks and needs should be completed. Inspectors expected this to include whether there were any child protection concerns involved.
44. In only 77% of cases inspected was there an initial assessment of the risk of serious harm to children, leaving nearly a quarter of cases inadequately assessed; a matter of considerable concern.
45. Table 3 sets out the findings of the file reading exercise in relation to the assessment of risk of harm.

Table 3 Quality of assessment	
Assessment Category	Percentage dealt with well (number of cases)
Contact with children	60 (18 of 30)
Who was at risk	85 (41 of 48)
What they were at risk of	79 (37 of 47)
From whom were they at risk	85 (40 of 47)
Protective factors	62 (28 of 45)
Risk factors	71 (32 of 45)
What action or circumstances might reduce the risk	57 (25 of 44)
What actions or circumstances might increase the risk	60 (27 of 45)
Gender issues	71 (12 of 17)
Race and ethnicity issues	56 (5 of 9)
Risk of sexual abuse	75 (15 of 20)
Risk of emotional abuse	71 (27 of 38)
Risk of physical abuse	80 (32 of 40)
Risk of neglect	69 (25 of 36)
Domestic violence	72 (18 of 25)
Mental disorder	74 (14 of 19)
Involvement of other professional agencies or individuals	85 (39 of 46)

Commentary

Most aspects of assessment, as set out in the above table, show the need for improvement. In particular:

- given that these cases all involved child protection issues, it was of concern that over a third of them did not contain a sufficient record of contact with children during the assessment period
- between seven and ten of the cases read did not contain a sufficient assessment of who was at risk, of what and from whom, three of the most critical questions in any risk assessment
- risk and protective factors are important in the development of a risk management plan and so it was of concern that around a third of cases did not contain a sufficient record
- file readers were looking for a dynamic assessment of risk to children and checked whether the assessment identified what might increase or reduce the risk. It was worrying that less than two-thirds of cases dealt with this well
- diversity issues were not always dealt with well, with five out of 17 relevant cases needing improved assessment of gender issues and five out of nine of race and ethnicity issues
- there are four types of risk of significant harm to children identified as reasons to place children on the ACPC Register. It is therefore important that probation files record this clearly to ensure those involved in the case are clear about the nature of the identified risk. The above table shows that this was not always the case. It was of particular concern that the identification of the risk of neglect was not dealt with well by supervising officers because this sort of case represented the largest group in the probation sample
- domestic violence and mental disorder was a feature in about one-third of cases each. There was room for some improvement in these assessments

- risk of harm to staff from the offender and others and the involvement of other professionals and agencies in risk assessment and risk management planning were amongst the best assessment practice
 - it was a matter of concern that only 41% of cases (20 of 49) dealt with all relevant assessment issues well or very well.
46. File readers checked in the assessment process and record whether probation staff showed particular alertness to the welfare of children. It was encouraging that in 83% of cases alertness to these issues was demonstrated, although there were seven cases where this was not so.
47. File readers were asked to describe any particularly good practice or areas for improvement. On assessment some of these comments were:
- “Extensive efforts were made by the PO to assess the child protection concerns.”
 - “The supervising officer did not link the excessive use of alcohol to possible consequences in the treatment and safety of the children.”
 - “Risk assessment documents did not allow for child protection issues to be covered.”
 - “Need for more explicit assessment on file of specific child protection concerns.”
48. As described in the background information, for children considered in need or at risk of significant harm social services should complete an Assessment Framework. Reference to this assessment was not found in three-quarters of cases. Although this may have been because social services had not completed one, this should have been noted on the case record. In meetings with staff, however, it was clear that only a minority of staff had a good understanding of the framework and expected to cross-reference it to their own assessment of the offender they were supervising.
49. At the time of the inspection the national roll-out of OASys was only just beginning and so in none of the cases inspected was OASys used as the assessment tool. A range of assessment tools was in use in the probation areas visited that covered the assessment of child protection concerns in different ways and in varying levels of detail. OASys will, if well administered, represent an improvement in the tool used by most areas for assessing such risk.

Probation area registers of child protection cases

50. Registration of cases for both high risk of harm offenders and child protection cases provides line and senior management with an opportunity to maintain oversight of cases by being able to identify them easily and to develop a system for routinely reviewing them.
51. Inspectors found a variety of approaches to registering cases as having a child protection concern. There were different definitions of what constituted a child protection case. Some included only those cases where a child was on the ACPC Register, but others included cases where there were known to be concerns about children in the same household as the offender, e.g. where the parents were chaotic drug users and there were concerns about the health and welfare of the children in the same household.
52. File readers checked whether cases had been promptly placed on a probation register of child protection concerns. Eighteen cases were within seven days but ten cases took longer than one month showing a lack of clarity about registration, a finding that

was supported by meetings with staff during the fieldwork stage. It was of concern that in only 73% of cases was there a clear record of the date the case was placed on the probation register of child protection cases.

Case and risk management

Case recording

53. It is essential that any probation case involving child protection issues is clearly and fully recorded and most areas had a practice guideline specifying this. The quality of case recording is one area of practice that arises repeatedly in HMIP inspections as an area for improvement and underlines the need for the development of a national case record. The evolution of the case record had been area-based and various forms of recording had developed. All areas had a case file that included basic case information, risk and needs assessments, supervision and risk management plans and contact logs. Files also contained key documents and correspondence. It was sometimes difficult to identify that a particular case had child protection concerns, whereas others were clearly flagged. Inspectors found little consistency in case records between and sometimes within areas. It was often difficult to find key documents and these were not always cross-referenced in the contact logs.
54. Contact logs are a record of day-to-day case related events. Sometimes these were an electronic record and sometimes handwritten. Table 4 shows the results from the file reading on the quality of contact logs:

Aspect of recording	Percentage where very good or good enough (number of cases)
Names and contact details for other key individuals	77 (37 of 48)
Telephone calls to and from other agencies	90 (45 of 50)
Letters to and from other agencies	89 (40 of 45) and 88 (36 of 41)
Attendance at case conferences	89 (32 of 36)
Decisions made at case conferences	84 (31 of 37)
Action plan arising from case conference	67 (22 of 33)
Membership of core group	49 (17 of 35)
Attendance at core group	68 (15 of 22)
Decisions made at core group meetings	61 (14 of 23)
Actions arising from core group meetings	59 (13 of 22)
Action taken by supervising officer towards plan	89 (25 of 28)
Action taken by other probation staff	90 (19 of 21)
Action taken by the senior probation officer (SPO)	59 (13 of 22)

Commentary

The above table shows that some recording was done well but improvements were required:

- the names and details of key individuals involved in a case should be clearly recorded and easily found but were not in nearly a quarter of cases

- recording of letters and telephone calls was good
 - most aspects of case conferences were recorded well except the action plan arising which was disappointing given its importance in relevant cases
 - recording of all aspects of core groups involvement needed improvement
 - although the action taken by the supervising officer and other probation staff in relation to plans was good, this was not so in relation to SPOs.
55. Other aspects of case records showed considerable need for improvement, particularly:
- the identification of child protection issues in initial supervision plans was sufficient in 63% of cases and cross-referenced to the risk assessment in only 53% of cases
 - only 24% of plans contained SMART objectives relating to child protection
 - the role of the supervising officer in relation to child protection was clearly stated in only 38% of cases
 - supervision plan reviews followed through the child protection issues in only 63% of cases. This poor performance highlights the need for clarity in defining the role of probation staff especially in relation to the child protection plan in these cases.
56. The file reading showed that in 79% of cases the contact levels with offenders were sufficient for the circumstances of the case, 62% of relevant cases had been breached in line with national standards, with a further 19% of breach action being taken outside the time limit. Given the need to supervise these cases to a high standard, these results were of concern with about one in five cases not meeting national standards. HMIP area inspections under the PIP (1999/2002) showed similar concerns about the management of high risk of harm cases, some of which would have concerned child protection issues. Although in 85% of cases the standard in relation to first contact was complied with, in only 66% of cases were appointments offered to the minimum number required by the national standard. For breach action it was of considerable concern that only 47% of cases met the standard, although performance had been improving towards the end of the period covered by these data.
57. File readers were asked to check whether a case had been held by one supervising officer or if it had been transferred. It was significant that only 31 (57%) of the cases had remained with one officer. Sixteen cases had been transferred within the area and seven from another area. Explanations for this transfer during the fieldwork interviews were sometimes related to staffing problems, restructuring and offenders moving. With so many cases being subject to transfer, and given the findings about the poverty of recording of some child protection issues, this highlights the risk of important information being lost.
58. One matter of considerable concern was the absence in many files of provision for confidential or third party information to be stored or, where there was, it was not clearly marked. In only 23 cases was there such a section that was clearly marked.
59. File readers were asked to describe any particularly good practice or areas for improvement. On case recording positive comments were:
- “Detailed contact log entries on discussions and decisions made at core group meetings – these were backed by the minutes of the meetings.”
 - “The awareness of the child and the partner’s protection is well documented and the risk/protective factors recorded.”

60. Comments highlighting areas for improvement were:
- “The case lacked a record of SPO involvement in discussion, decisions and actions.”
 - “No conversation was followed up in writing.”
 - “A section in the file for names and addresses of other agencies/workers would have been useful.”
 - “The case record does not have sufficient planning documentation in clear and explicit form.”
 - “Better checks needed in terms of all dates/information identified on the file.”

Case conference and core group involvement

61. The file reading showed that in 56% of relevant cases the supervising officer attended all or the majority of case conferences. In the remainder they attended none at all or the minority and in 21% of cases the record was not clear on attendance. Although this aspect was not specifically examined, HMIP considered that it was good practice for probation supervising officers to provide a written report if unable to attend. Comments from file readers on the main reason for non-attendance at case conferences showed that short notice was cited in a cluster of cases. This perhaps links to the comments in the next section on communication from social services.
62. Core group involvement was less well recorded than other issues as commented on above in table 4. HMIP considered that it was good practice for action arising from both case conferences and core groups to be reflected in supervision plans and reviews.

Inter-agency communication and liaison

63. Most cases involving child protection issues will involve some liaison with other agencies. This can vary from a brief telephone or written communication to a complex multi-agency risk assessment and management strategy. Communication and liaison are carried out in the context of inter-agency protocols and formal and informal agreements.
64. Table 5 looks at how well probation staff liaise with other agencies or individuals.

Table 5 probation staff liaising with others	
<i>Focus of liaison</i>	<i>Percentage where very good or good enough (number of cases)</i>
Identification of child protection concerns	81 (42 of 52)
Assessment of child protection concerns	74 (37 of 50)
Placing or removing a case on/from a probation register	78 (35 of 45)
Supervision plans	56 (27 of 48)
Risk management	71 (35 of 49)
Closure or termination of a case	75 (9 of 12)

Commentary

The above table shows that the quality of liaison varies and could be improved across the board. In particular:

- where child protection concerns had been identified by probation staff, this was communicated well in 42 out of 52 cases, leaving ten cases where this should have been better. This would have included probation staff taking an active role in contacting other agencies, primarily social services, to check whether a case had such concerns
- assessment was communicated well in only three-quarters of cases, with registration slightly better
- liaison over supervision plans needed considerable improvement. It was expected that where child protection featured in the plan discussion would have taken place with other agencies. Although better there was also room for improved liaison over risk management and the closure of cases.

65. In relation to liaison and communication on the part of other agencies, this was mainly very good. Education, health and the courts all achieved over 90%. The police, prisons, and the CPS achieved between 84% and 86%. Social services did least well with 77%, but they also dealt with far more of the cases in the sample than any other agency.

66. File readers were asked to describe any particularly good practice or areas for improvement. On inter-agency communication and liaison some of these comments were:

- “There was good contact with social services.”
- “Social services reluctance to follow through their own case conference recommendations should have been taken up at a higher level.”
- “The PSR writer became aware of the offender’s contact with social services but did not contact them to get further details.”
- “Excellent communication for the majority of the time between professionals involved.”
- “Police, social services and probation worked very effectively together.”

Diversity

67. There were very few cases in the file reading samples where the offender was from a minority ethnic group. There were two cases and, of these, one appeared to be well supervised and the other less well supervised. With such small numbers it was not possible to draw any firm conclusions about the quality of practice. However, there were indications from both the file reading and the meetings with staff that diversity issues in general were not dealt with well. There was a high number of cases where the race and ethnicity were not recorded. Staff found it difficult to identify how they ensured that diversity issues were properly reflected in their child protection related work. In many areas staff were dealing with predominantly white offenders and did not have the experience or resources to deal with minority ethnic cases when they arose. Areas were quick to recognise this and some were taking action to address their deficits.

68. File readers were asked to describe any particularly good practice or areas for improvement. On diversity some of these comments were:

- “Clear understanding demonstrated of the experience of racism as a factor in the offender’s life.”

- “Good practice in the use of interpreters and acknowledgement of cultural issues.”
 - “Clear understanding of history of brain injury and effect on cognitive functioning and the need for appropriate support systems to be in place to support the family.”
69. Most areas had good access to interpreters, although it was not clear if they had been screened to see if they were suitable to work on cases involving child protection issues.
70. In areas where there was a growing number of refugees and asylum seekers, work had been done to improve support services available to probation staff (e.g. in London there was an advice line).
71. Issues for women and children affected by domestic violence were identified as a specific area for improvement.

Management oversight of cases

72. In all areas, even those with significant recruitment difficulties, there were robust systems for supervision and appraisal and staff reported having had regular discussions with their line managers about difficult cases. Although supervision was clearly being carried out, there was evidence from the file reading that management oversight of cases needed improving, e.g. only 59% of contact logs recorded sufficiently the action taken by line managers; overall, file readers considered there was sufficient line management oversight in 68% of cases. In relation to senior managers, it was of considerable concern that their oversight of, and involvement in these cases was only good enough in 55% of cases.
73. There was a variety of approaches taken to oversight of cases by senior managers and, again, there was an absence of national guidance on their role in relation to child protection cases and registers. Clarification was required in order to ensure consistency of approach in relation to these cases. HMIP considered that knowledge of these cases would assist the ACPC representative in their role.
74. There was little evidence of training having been undertaken by line managers to equip them for their specific role, nor were managers required to have a minimum level of knowledge and understanding of child protection before taking responsibility for practitioners holding these cases.

Risk management

75. The file reading showed that, while some aspects of risk management were addressed well, there were areas requiring attention, in particular:
- it was encouraging that the supervising officer was either very alert or alert enough to child protection issues in 85% of cases, although there were six cases where they were not alert enough
 - in 58% of cases the risk management plan in relation to children was at least good enough, leaving a lot of room for improvement
 - actions identified for probation staff as part of the risk management plan were followed through at least well enough in 72% of cases.

76. In 24 of the 54 cases something happened to increase the risk of significant harm to a child. Of these, in 16 cases probation staff took all appropriate steps but in six cases they did not or could have done better; a worrying proportion. In the other two cases the record was not clear enough for the file reader to determine a finding.
77. File readers were asked to describe any particularly good practice or areas for improvement. On risk management some of these comments were:
- “Extensive efforts were made by the PO to deal with the child protection concerns.”
 - “The PO was addressing the risks in one-to-one work above any national standards requirements.”
 - “Immediate response to events likely to increase risk.”

Chapter 8 reviews

78. Probation areas are not involved directly in many of the Chapter 8 reviews undertaken by ACPCs. However, there are often findings and recommendations which are relevant and which should be considered and lessons disseminated.
79. Few areas had clear guidance in relation to probation involvement in Chapter 8 reviews including how they related these to their own reviews of serious incidents, e.g. where a child is seriously harmed by an offender who is under the supervision of the probation service, an internal review should always be conducted and it is probable that in these cases there would be a simultaneous Chapter 8 review.
80. In the national survey eight out of the 40 areas responding reported that there had not been a Chapter 8 review in their area since 1 April 1999. Eighteen had had one or two, ten areas between three and seven and one area nine and another 16.

Appendix 1

STANDARD 1: ARRANGEMENTS BY AGENCIES TO SAFEGUARD CHILDREN

All agencies whose staff (including volunteers) have contact with children and/or families have in place clear policies, strategies and procedures to ensure the safeguarding of children.

Criteria

- 1.1 Agencies have clear strategic plans and policies that prioritise the safeguarding of children and promote their welfare, and involve users and their representatives in the development of these plans.
- 1.2 All agencies working with children and families plan and develop services within the common framework of the local community safety and children's services plans.
- 1.3 All agencies have clear policies to promote equalities issues and monitor services to ensure that no child is discriminated against due to age, gender, race, culture, religion, language, disability or sexual orientation.
- 1.4 Managers and/or senior staff ensure that staff and volunteers are aware of their responsibilities to ensure the safeguarding of children and have received training to enable them to fulfil this responsibility.
- 1.5 Recruitment policies and procedures conform with legislation and guidance.
- 1.6 Staff (including volunteers) have their safeguarding checks updated as required by legislation and guidance, and these are properly recorded.
- 1.7 Foster carers and other people in their homes are checked, and these checks are updated, as required by legislation and guidance.
- 1.8 Managers and/or senior staff ensure that staff listen to and respond appropriately to the concerns of children and young people.
- 1.9 Managers and/or senior staff promote a culture within their agency that ensures children as individuals are respected at all times and that their welfare is promoted.
- 1.10 Agencies have effective complaints procedures and whistle-blowing arrangements.
- 1.11 Managers and/or senior staff ensure that staff are effectively supported and protected from danger and/or the risk of violence.
- 1.12 Agencies have clear procedures in respect of allegations against staff, volunteers and others with the care of children, and monitor and ensure the effectiveness of these procedures.

STANDARD 2: THE SAFEGUARDING OF CHILDREN IN ALL SETTINGS AND CIRCUMSTANCES

Agencies have local policies and procedures that address the safeguarding of children living away from home and in other circumstances where they are known to be particularly vulnerable.

Criteria

- 2.1 The ACPC procedures cover all situations where children live away from home.
- 2.2 Agencies have in place clear and unambiguous procedures in respect of child protection, consistent with local ACPC arrangements, in all settings where children live away from home, and monitors the implementation of them.
- 2.3 Local safeguarding arrangements address equalities issues and ensure the children do not experience discrimination, and receive protection when they require it.
- 2.4 There are clear policies and procedures that are monitored in respect of any allegations made against any professional, carer, foster carer or volunteer in any situation where children are living away from home.
- 2.5 The ACPC has in place and monitors a protocol with the Youth Offending Team (YOT) that addresses issues of safeguarding in respect of all children and young people who commit offences against other people, including specifically the safety of all children and young people remanded or sentenced to custodial institutions.
- 2.6 The ACPC works with others to ensure that responses to issues of domestic violence by any agency address child safeguarding issues.
- 2.7 The ACPC, working with others has proactively addressed and put in place strategies to address the needs of children involved in prostitution or subject to sexual exploitation or go missing.

STANDARD 3: THE COORDINATION AND MONITORING OF THE CHILD PROTECTION SYSTEM

The ACPC ensures agencies work collaboratively to develop and implement joint systems for ensuring the safeguarding of children, and monitors and evaluates the effectiveness of the child protection services.

Criteria

- 3.1 The ACPC is constituted as required by *Working Together to Safeguard Children* and has appropriate representation from all relevant agencies including those from the voluntary sector at an appropriate level of seniority.
- 3.2 The ACPC ensures that local policies, procedures and protocols are up to date, consistent with statute, Regulations and national Guidance, and fully owned by all local agencies involved with the protection of children.

- 3.3 The ACPC actively addresses issues of diversity and equality, monitors child protection, and takes action to address these where necessary.
- 3.4 The ACPC has adequate resources to fulfil its responsibilities.
- 3.5 The ACPC has put in place objectives and performance indicators for child protection, and uses management information in respect of child protection and safeguarding of children to improve services.
- 3.6 The ACPC has a regular programme to review local services to safeguard children, evaluates performance and takes action to improve effectiveness.
- 3.7 The ACPC has a Business Plan supported by robust planning processes, and this includes plans to address issues identified in reviewing and evaluating local services.
- 3.8 The ACPC encourages and promotes effective working relationships between different services and professional groups, based on trust and mutual understanding.
- 3.9 The ACPC has a strategy that is being implemented to raise awareness within the wider community of the need to safeguard children and promote their welfare, and to explain to the wider community how they can contribute to these objectives.
- 3.10 Where the boundaries between the local authorities, the health service and the police are not co-terminus, the ACPC has addressed the issues and sought to establish as far as possible common procedures and protocols, and sought to collaborate on inter-agency training.

STANDARD 4: HOW WELL DO LOCAL ARRANGEMENTS TO SAFEGUARD CHILDREN WORK

Child welfare concerns are identified and responded to appropriately and sensitively with agencies working in partnership to ensure children are effectively safeguarded.

Criteria

- 4.1 Staff of all services in contact with children and/or their parents, have a clear understanding of their duties and responsibilities, and are trained and supported to identify potential child welfare concerns and know how to respond to them.
- 4.2 All services are provided in a way that ensures the safety of all children and respects the individuality of each child, and ensures there is no discrimination in respect of age, gender, race, culture, religion, language, disability or sexual orientation.
- 4.3 The Assessment Framework has been implemented on a multi-agency basis as an integral part of *Working Together*.
- 4.4 Staff of all services have a consistent understanding of the thresholds for sharing information with and referral to the social services department/police, and the undertaking of an initial assessment to identify if the child is in need and, if so, if the child's welfare is being safeguarded.

- 4.5 Responses to child welfare concerns, including those that progress to Section 47 enquiries and core assessment, child protection registration, and the development, implementation and review of child protection plans, are conducted in accordance with local policies, procedures and guidance by all agencies.
- 4.6 Agencies in the judicial process have in place policies and procedures based on legislation and guidance that are implemented to support child protection services.
- 4.7 Plans for the protection of children set clear objectives to ensure their safety and are regularly monitored and reviewed by each agency to ensure that the plans are being implemented and are effective.
- 4.8 Responses to ensure the safety of children respect the rights, privacy and dignity of parents and carers as far as possible without jeopardising the child's safety, recognise the stress that such interventions can cause, and seek to ensure that families are supported and services to support parenting/care are put in place.
- 4.9 All agencies ensure that arrangements are put in place to safeguard children in any service they commission on behalf of children.

STANDARD 5: INFORMATION SHARING

Information for the purposes of safeguarding children is shared appropriately between agencies.

Criteria

- 5.1 There are clear protocols between the ACPC constituent agencies for the sharing of information.
- 5.2 There are systems in place to monitor, review and evaluate the sharing of information to safeguard children.
- 5.3 Agencies undertake regular audits in respect of the sharing of information, and act upon the findings to ensure that children are safeguarded.
- 5.4 Staff understand, accept and implement the protocols and guidance on information sharing.
- 5.5 Recording and sharing of information addresses the requirements of relevant data protection legislation, human rights legislation, anti-discrimination legislation and court proceedings legislation.
- 5.6 Case records kept by agencies in respect of children where there are welfare concerns, are accurate, up to date and of a high standard.

STANDARD 6: KNOWLEDGE AND SKILLS

The ACPC ensures that staff (of the constituent bodies of the ACPC) who undertake work to safeguard children are well informed in respect of good practice and are appropriately skilled for the tasks.

Criteria

- 6.1 The ACPC has a strategic plan for inter-agency training of staff.
- 6.2 Staff of all ACPC constituent agencies are trained and supported in their work to protect children, and that this training is based upon up-to-date knowledge and skills.
- 6.3 The ACPC ensures that staff have the necessary knowledge and skills to protect children in a manner that is sensitive to issues of race, religion, culture and disability.
- 6.4 The ACPC and agencies ensure staff work to national and local guidance.
- 6.5 The ACPC has effective links to ensure that it keeps up to date with the growing body of research evidence and knowledge that should inform good policy and practice in work to safeguard children, including children from black and minority ethnic groups and those with a disability.
- 6.6 The ACPC has effective systems to ensure that its members and their agencies learn from local and national experience in respect of safeguarding children.

STANDARD 7: CASE REVIEWS CONDUCTED IN ACCORDANCE WITH CHAPTER 8 OF WORKING TOGETHER TO SAFEGUARD CHILDREN

The ACPC conducts case reviews under the guidance of Chapter 8 of *Working Together to Safeguard Children* effectively and ensures that appropriate lessons are learnt and changes to practice implemented to maximise safeguarding for children.

Criteria

- 7.1 The ACPC has clear criteria consistent with the guidance for establishing a Chapter 8 case review.
- 7.2 The ACPC has established, when required, a Serious Cases Review Panel involving a minimum of social services, health, education and the police.
- 7.3 Serious case reviews are set up and conducted in a manner that is sensitive to issues of race, culture, religion and disability.
- 7.4 When a review is required, relevant agencies conduct individual management reviews to consider their involvement with the child and family, and identify changes that need to be made in individual and organisational practice.

- 7.5 The ACPC commissions an overview report that brings together and analyses the findings of the individual Management Reviews and any other reports commissioned, and includes an executive summary that is made public.
- 7.6 Recommendations from individual Management Reviews and the overview report are carefully considered by individual agencies and by the ACPC, with required changes in practice implemented within the timescales set out in the action plan.
- 7.7 The ACPC monitors action plans, and evaluates the effectiveness of their implementation.

The role and responsibility of an ACPC

The role and responsibility of an ACPC is outlined in Chapter 4 of *Working Together to Safeguard Children*. This guidance states that all local authorities, in exercising their social services functions, should ensure that there is an ACPC covering their area, which brings together representatives of each of the main agencies and professionals responsible for helping to protect children from abuse and neglect. The ACPC is therefore an inter-agency forum for agreeing how the different services and professional groups should cooperate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children.

The specific responsibilities of an ACPC, as outlined in paragraph 4.2 of *Working Together to Safeguard Children* are:

- to develop and agree local policies and procedures for inter-agency work to protect children, within the national framework provided by this guidance;
- to audit and evaluate how well local services work together to protect children, for example through wider case audits;
- to put in place objectives and performance indicators for child protection, within the framework and objectives set out in Children's Services Plans;
- to encourage and help develop effective working relationships between different services and professional groups, based on trust and mutual understanding;
- to ensure that there is a level of agreement and understanding across agencies about operational definitions and thresholds for intervention;
- to improve local ways of working in the light of knowledge gained through national and local experience and research, and to make sure that any lessons learnt are shared, understood, and acted upon;
- to undertake case reviews where a child has died or – in certain circumstances – been seriously harmed, and abuse or neglect are confirmed or suspected. To make sure that any lessons from the case are understood and acted upon; to communicate clearly to individual services and professional groups their shared responsibility for protecting children, and to explain how each can contribute;
- to help improve the quality of child protection work and of inter-agency working through specifying needs for inter-agency training and development, and ensuring that training is delivered; and
- to raise awareness within the wider community of the need to safeguard children and promote their welfare and to explain how the wider community can contribute to these objectives.

ACPC Membership

The membership of an ACPC should be determined locally but should include representatives of the main agencies responsible for working together to safeguard children:

- local authorities (education and social services);
- health services (both managerial and professional responsibilities);
- the police; and
- the probation service.

When active in the area membership should also include:

- the domestic violence forum;
- the armed services; and
- the National Society for the Prevention of Cruelty to Children (NSPCC).

The ACPC should make appropriate arrangements to involve others in its work as needed.

Those with relevant interest may include:

- adult mental health services;
- child and adolescent mental health services;
- the coroner;
- the CPS;
- dental health services;
- drugs and alcohol misuse services;
- education establishments not maintained by the local authority;
- Guardian Ad Litem panels (now replaced by the Children & Family Court Advisory Support Service [CAFCASS]);
- housing, cultural and leisure services;
- the judiciary;
- local authority legal services;
- prisons and youth detention centres;
- representatives of service users;
- sexual health services;
- voluntary agencies providing help to parents and children;
- witness support services; and
- YOTs.

Appendix 3

The eight local authority areas chosen for the fieldwork were:

- Hammersmith and Fulham (London Probation Area)
- Harrow (London Probation Area)
- Nottingham City (Nottinghamshire Probation Area)
- Kent (Kent Probation Area)
- Surrey (Surrey Probation Area)
- North Yorkshire (North Yorkshire Probation Area)
- Shropshire (West Mercia Probation Area)
- Stockport (Greater Manchester Probation Area).

Appendix 4

Profile of the cases read for the inspection		
Number of case files read		54
Gender of offender	Male	31
	Female	23
Ethnicity of offender	White	36
	Black	2
	Not recorded	16
Order/Licence	Community Rehabilitation Order	39
	Community Punishment and Rehabilitation Order	2
	Licence	5
	Other	6
If on ACPC Register, category of harm	Physical	7
	Emotional	2
	Sexual	1
	Neglect	14
	Combination	9
Nature of risk to children as described by file reader	Violence	22
	Neglect	22
	Emotional abuse	10
	Sexual abuse	8
	Drug misuse	8
	Alcohol misuse	8
	Domestic violence	8
Main source of risk of harm to child	Offender	42
	Another person	10
Case on the ACPC Register currently	Yes	16
	No	26
	Not clear	11

Appendix 5

The following are the recommendations relevant to the NPS from *Safeguarding Children, A joint Chief Inspectors' Report on Arrangements to Safeguard Children*:

The Department of Health, Home Office, Department for Education and Skills, and the Lord Chancellor's Department should:

- Ensure the safeguarding of children is firmly and consistently reflected in national and local service planning.
- Support and facilitate national and local agencies to recruit and retain sufficient levels of appropriately qualified staff, paying particular regard to the image, status, morale, remuneration and working conditions of specialist child protection staff.
- Establish minimum expectations, standards and curriculum for child protection training as part of the core professional training of all professionals working with children and young people (e.g. teacher training, medical and health staff training, police training, etc.).

The Lord Chancellor's Department, the Home Office and Department of Health should:

- Ensure that there is clear guidance provided to all agencies under their respective responsibilities on the implications of the Data Protection Act 1998 and the Human Rights Act 1998 and other relevant law, in respect of sharing information about children where there are welfare concerns.

The Home Office should:

- Ensure that safeguarding children and young people is a national priority for police services and the NPS as part of their public protection arrangements, and ensure that this priority is reflected in local service plans.
- Ensure that the relationship between MAPPPs and ACPCs is clarified.
- Implement a national policy framework for public protection, including MAPPPs and wider children's safeguarding issues, as a matter of priority in order to develop a more consistent approach to the assessment and management of potentially dangerous people.
- Issue a set of national standards and performance measures for police and probation services' joint management of potentially dangerous offenders.

All Relevant Inspectorates should:

- Review their inspection activity to ensure that there is sufficient emphasis on examining arrangements to safeguard children.
- Ensure that prior to the next report appropriate inspection activity has been undertaken on the following safeguarding areas:
 - ▶ Young Offender Institutions (YOIs)
 - ▶ the impact of domestic violence on children
 - ▶ unaccompanied asylum seeking children and the children of refugees and asylum seekers
 - ▶ the work of YOTs.

ACPCs with their Constituent Agencies should:

- Develop integrated planning processes in partnership with MAPPPs to ensure that the safeguarding of children is an individual agency and inter-agency priority.
- Review their constitution, membership, level of representation and funding arrangements to ensure that the committee is adequately resourced and fit for purpose to lead the children's safeguarding agenda across the area and in all relevant settings.
- Ensure that there is an appropriate range and quantity of joint and single agency training to meet the needs of the workforce of constituent agencies (including non-specialist staff), relevant voluntary and independent organisations in their locality, and agree minimum expectations in terms of attendance and content of training.
- Ensure that there are robust management information processes to support the monitoring, evaluation and auditing of local child protection procedures and practice.
- Ensure that reviews of serious cases are undertaken on all appropriate cases within the timescales and expectations of Chapter 8 of *Working Together to Safeguard Children*, that reports are circulated appropriately and action plan recommendations are implemented.
- Develop explicit arrangements for sharing information within a framework of joint protocols in order to strengthen the safeguarding of children.
- Ensure that concerns about the safety of young offenders are identified and addressed in partnership with the local YOT, YOIs and prisons.
- Review the local arrangements for maintaining and accessing the child protection register to ensure that relevant information is captured and used to maximise the safeguarding of children.

Appendix 6

The following are the recommendations from HMIC's/HMIP's *Protecting Children from Potentially Dangerous People*, an Inter-Agency Inspection on Children's Safeguards:

ACPO and the NPS should:

- ensure that a national framework for MAPPA is implemented as a matter of priority in order to develop a more consistent approach to the assessment and management of very high risk of harm offenders. This should include:
 - ▶ structure, including membership of MAPPPs
 - ▶ information sharing
 - ▶ referral thresholds and assessment procedures for MAPPPs
 - ▶ risk management procedures and plans
 - ▶ appropriate resourcing
 - ▶ monitoring and reviewing effectiveness of MAPPPs
 - ▶ minimum training expectations
 - ▶ MAPPP links with ACPCs
- agree a set of national standards and performance measures for their joint management of offenders presenting a very high risk of serious harm to the public
- develop a national strategy for the identification and dissemination of lessons from research and experience in the assessment and management of very high-risk offenders
- ensure that documentation relating to original index offences is available to appropriate agencies during sentence and upon release.

GLOSSARY OF ABBREVIATIONS

ACO	Assistant chief officer
ACPC	Area Child Protection Committee
CAFCASS	Children & Family Court Advisory Support Service
CPS	Crown Prosecution Service
GBH	Grievous bodily harm
HMIP	HM Inspectorate of Probation
MAPPA	Multi-Agency Public Protection Arrangement
MAPPP	Multi-Agency Public Protection Panel
NPD	National Probation Directorate
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
OASys	Offender Assessment System
OFSTED	Office for Standards in Education
PIP	Performance Inspection Programme
PO	Probation officer
PSO	Probation service officer
PSR	Pre-sentence report
SPO	Senior probation officer
SSI	Social Services Inspectorate
YOI	Young Offender Institution
YOT	Youth Offending Team