Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Safeguarding Report

April 2013 – March 2015

Contents

1. Executive summary **2**

2. Introduction **5**

3. Learning the lessons from deaths in custody **6**
Information sharing and risk assessment 7
Looked-after children 8
Roles and responsibilities of YOTs 9

4. Summary of community safeguarding and public protection incident data **11**
Data analysis 12
Next steps 17

5. Behaviour management in the young people's secure estate **19**
Use of restrictive physical intervention (RPI) 19
Self-harm by young people in custody 20
Assaults involving young people in custody 20
Single separation 20
Implementation of minimising and managing physical restraint 21

6. Safeguarding policy, evidence and research **23**
The YJB's approach to safeguarding and child protection 23
Activities to support the safety and well-being of children 24
Research and guidance 26

7. Next steps **30**

Annex A: An outline of contents specific to youth justice from the Department for Education's statutory guidance, 'Working Together to Safeguard Children' (2015) **33**

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1. Executive summary

This report provides a compendium of information and resources for anyone who wants to know about safeguarding incidents in the youth justice system over the past two years. It draws together information about lessons learnt from a variety of safeguarding incidents and provides practitioners and managers with sources of information to support practice improvement and stronger arrangements for the safeguarding of children. The report also provides information on the steps the YJB has taken to meet our *Commitment to Safeguard*. The report is set out in five key sections.

Learning the lessons from deaths in custody

Seventeen children have died in custody since 2000. The most recent death was of a boy at Cookham Wood Young Offender Institution (YOI) in July 2015. The investigations into his death are ongoing.

During 2011 and 2012 there were three self-inflicted deaths in YOIs, and the investigations into the circumstances of these deaths concluded within the past year. The key areas of concern identified in the investigations are as follows:

- information sharing
- placement decisions
- systems to support children at risk of self-harm or suicide
- access to health services, particularly mental health support
- support networks for children in custody, particularly for looked-after children
- the management of bullying in YOIs

These lessons are relevant to the Youth Justice Board for England and Wales (YJB), youth offending teams (YOTs) and secure estate providers, as well as a range of mainstream service providers.

Community safeguarding and public protection incident data

The YJB requires that YOTs report safeguarding and public protection incidents involving the children they supervise. In 2013, a new system for reporting and reviewing such incidents was introduced, and between April 2013 and March 2015, YOTs reported 467 incidents. Reviews of the critical learning exercises undertaken by YOTs following these events have identified some key themes where services may want to consider a review of practice. Several examples of good practice have also been identified.

In 2014, the effectiveness of the new system for reporting incidents was reviewed by the YJB and by HM Inspectorate of Probation (HMIP). The

conclusions of both reviews were broadly similar, finding that the IT system used for reporting incidents was not adequate for the purpose; that not enough was being done at a national level to share information about trends and data, and that local practice for reviewing incidents and learning lessons was highly variable. Work has now begun to address these findings and will result in revised and streamlined systems being introduced by the end of March 2016.

Behaviour management in the young people's secure estate

The behaviour management data collected by the YJB covers four types of incident in the secure estate for children:

- the use of restrictive physical interventions (RPIs)
- self-harming
- assaults involving young people
- single separation in secure training centres (STCs) and secure children's homes (SCHs)

In 2013/14, the rate of RPIs per 100 children in custody rose when compared to the previous two years. Self-harming also increased, as did the rate of assaults involving young people. The use of single separation in STCs and SCHs decreased.

There is no doubt that shrinking numbers in custody and the corresponding reduction in the size of the secure estate for children has resulted in a more concentrated mix of children who have significant risk factors to themselves and to others. The introduction of the medically approved Minimising and Managing Physical Restraint system in YOIs and STCs is expected to help staff to de-escalate and manage children's most challenging behaviour. Meanwhile, the current work to develop YOI provision seeks to make custody a more supportive environment for children, enabling them to experience some benefits from their time in custody.

Safeguarding policy, evidence and research

During the past two years, the YJB has undertaken a range of internal and external activities to strengthen arrangements for safeguarding children in custody. This has included:

- publication of a safeguarding statement
- production of a bespoke child protection policy for YJB staff
- a project to improve information sharing at the point when children enter custody
- strengthening complaints handling in STCs
- establishing a regular section in the Youth Justice Bulletin focusing on the topic of the safety and well-being of children

The YJB's work has been supported by a range of additional research and evidence produced by others, such as the first annual report from the National Panel of Independent Experts on Serious Case Reviews. This made valuable conclusions about practice, which were echoed in the reviews of community safeguarding incidents conducted by YOTs. 2015 also saw the publication of revised statutory safeguarding guidance containing important advice for those working with children in the youth justice system. Key publications are summarised in section four.

Next steps

In the coming months, we will be focusing on delivering improvements to the safety and well-being of children in the youth justice system through:

- the implementation of AssetPlus
- an improved incident reporting process for the community and secure estate
- strategic work to support work that tackles child sexual exploitation and abuse
- development of a bespoke safeguarding module within the YOI reform programme
- implementation of the Social Services and Well Being (Wales) Act 2014 in Wales

The safety of children in the youth justice system is a single aim that all those in the sector share, both as a goal and as a duty. We will remember this during challenging times and periods of change.

2. Introduction

The principal aim of the youth justice system is to prevent offending by children. The YJB advises the Secretary of State on how to achieve this, and, within this advice, recognises that children at risk of offending are a complex group at greater risk of harmful behaviours, both to themselves and others, compared to most other children. The YJB undertakes other statutory functions, as set out by the Crime and Disorder Act 1998 and the Youth Justice Board for England and Wales Order 2000, as amended.

It is through these statutory functions that the YJB outlines its commitment to contribute to safeguarding and promoting the welfare of children in contact with the youth justice system, and supporting the youth justice sector in the delivery of their safeguarding duties.

This is the first of the YJB's Safeguarding Reports. As an initial report it covers the period of April 2013 – March 2015, and will in future be published annually. The report highlights learning identified from community and custody safeguarding incidents. It presents the themes and issues which have arisen from these which have national relevance, and also provides details of safeguarding research and guidance which can support the sector in improving the safety and well-being of children.

This report explains how the YJB has shared learning with colleagues and stakeholders to improve policy and the development of effective practice across the youth justice system and beyond.

3. Learning the lessons from deaths in custody

The death of any young person in custody is clearly both tragic and shocking. The investigations carried out in response offer insights into the time these young people spent in custody and draw attention to areas of policy or practice where changes and improvements are needed.

The investigations into the 16 deaths of young people in custody that occurred between 2000 and 2012 have now all been completed; the most recent of these deaths being in January 2012, for which the inquest closed in December 2014. All of these deaths were self-inflicted except one, which was restraint-related.

In July 2015, a boy died at Cookham Wood YOI. Though his death is thought to have been linked to natural causes, the outcomes of the related investigations are awaited. The YJB and all the organisations involved in his care in custody will continue to work with investigators to understand what learning and improvements are required.

During the 2011/12 period, there were three deaths of young people within youth custody. In each case there have been investigations into the circumstances of these deaths by the police, the Prisons and Probation Ombudsman[1] and the Local Safeguarding Children's Board (in the form of a Serious Case Review[2, 3]); each will also be the subject of an Inquest hearing.

The YJB has explored the findings available from these investigations and identified the areas of thematic learning that have been highlighted from them. These have included the following:

- information sharing, and the impact on appropriate and effective risk assessments
- placement decisions, including the review of initial placements and the process for transfers
- the operation of systems in place to support young people at risk of self-harm and suicide
- access to health services – particularly mental health services for children in the youth justice system

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[1] The Prisons and Probation Ombudsman investigates all deaths in custody. This includes any deaths in the secure estate for children and young people, but also those among adult prisoners, immigration detainees and the residents of probation hostels (Approved Premises).

[2] Serious Case Reviews consider how well organisations are working together to safeguard and promote the welfare of children and provide lessons and recommendations to support improvement.

[3] In Wales, the equivalent investigation would be a Child Practice Review.

- access to support networks for the young person, specifically the Personal Officer Scheme, and more widely, facilitating contact with young people's families and carers
- management of bullying and harassment within YOIs
- looked-after children in custody

A number of the lessons identified have informed the development of the secure estate and the requirements the YJB makes of providers, through their operating specifications, when commissioning youth custody. The operating specifications for both the secure training centre (STC) retendering exercise and the YOI Reform project[4] – which outline the YJB's expectations on how custody is delivered to children – include learning from deaths in youth custody. They include requirements such as:

- a more bespoke support role for young people in custody, with expectations around purposeful relationships and the need for staff to understand and fully relate to young people
- appropriate sharing of information, particularly when:
    - a young person is being managed as at risk of suicide and self-harm
    - key events have occurred and are followed by staff changes (shift changes)
- ensuring the process used for managing children at risk of self-harm and suicide provides:
    - consistent management of those young people
    - a key individual responsible for co-ordinating the information, input of others and appropriate interventions that contribute to managing these children

Areas of thematic learning have also been identified for YOT practitioners. These have been disseminated through the YJB's Business Area Teams and YJB Cymru to youth offending teams (YOTs) to support improvements in policy and practice. These have included the following areas of learning.

Information sharing and risk assessment

YOTs have a clear role to play in the quality of the information provided when a young person transfers from community into custody. In many cases they hold the most knowledge of an individual young person's needs and their history, and are expected to pass on this knowledge to support the care and management of young people as they move from the community into custody.

To do this most effectively, practitioners were reminded of:

- the impact of **missing documentation** on effective placement and the assessment of a young person's risks to safety and well-being, and the

[4] In under-18 YOIs, delivery against the operating specification is currently in a phase of development by NOMS Young People's Team before any implementation can begin.

resulting impact on the management of the safety and welfare of the young person once they enter custody

- the need for YOT staff and other community based services to be better informed of the **Person Escort Record** (PER),[5] and, as a minimum, request to view the PER to enable the information contained to be factored into their own risk assessments through the post-court report
- their role in **transfer decisions**, and that, where they consider that the young person's needs demonstrate they would benefit from placement in an alternative establishment, the YOT should present this case. In doing so, the YOT should clearly highlight the key factors driving the case so that the needs of the individual can be best met. YOTs are expected to articulate their knowledge of young people to support the care and management of these young people as they enter custody and during their time there
- the importance of proactively **sharing information** in the best interests of the child and making contact with other agencies to do the same (for example by making GPs/CAMHS services aware that young people have been sentenced to custody so that they can share medical records with the establishment).
- Fears about sharing information shouldn't stand in the way of actions to protect the safety and welfare of children. Actively sharing information and making contact with appropriate agencies to support the needs of the young people in the justice system should be seen as best practice. This is set out in the Department for Education's statutory guidance *Working Together to Safeguard Children* 2015, which supports the use of information sharing as a tool to effectively safeguard children and young people
- the need to use the established mechanisms[6] for **transferring information effectively** when a child enters custody, so as not to dilute quality through multiple entry

Looked-after children

There has been a strong focus on supporting the needs of looked-after children, both when they are in the community as well as during their time in custody. The criminalisation of looked-after children within the youth justice system has been highlighted through the findings of death in custody investigations, as well as how the status of being looked after negatively impacts on decisions to escalate involvement in the justice system, leads to custodial outcomes and/or

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[5] The Person Escort Record (PER) is an inter-agency document supplied by the National Offender Management Service (NOMS) and used to ensure information about individuals in custody, and the presenting risks they may pose to themselves and others, is available to those responsible for them as they pass between agencies. It is used when escorting either adults or young people and is a paper-based document that is hand written. Where there may be concerns about safety and well-being, these are flagged on the PER with the use of a suicide and self-harm warning form.

[6] By the use of Connectivity, a system designed to securely send information and pre-populate eAsset, the case management system used by the YJB Placement Service and secure establishments.

impacts on early release decisions. YOTs have a vital role to play in supporting changes in these areas of concern and were reminded of their role to:

- facilitate strong relationships between the YOT and Children's Services to ensure co-ordinated care planning and review
- recognise that looked-after children placed out of area remain the responsibility of their home authority (as corporate parent), and that this adds to the complexities of managing some looked-after young people. Interaction with both home and host YOTs and the responsible and hosting local authority children's services is key to ensuring information is shared and care planning is co-ordinated and appropriate
- be mindful of particular issues affecting looked-after children (for example, accommodation and access to support networks), especially in applications for bail and early release
- carefully consider breach and compliance, recognising the need for a flexible approach to looked-after children that looks at holistic achievement to consider how compliance can be improved without escalation in the criminal justice system

Roles and responsibilities of YOTs

YOTs have a very important role to play in safeguarding young people. This applies in custody, as much as in the community. Practitioners were reminded that, as caseholders, they:

- **remain responsible for ensuring the safety and welfare of a young person in custody**, especially when the young person is considered to be at risk of self-harm and suicide; they should be actively involved in managing the risks alongside other agencies, such as the establishment
- have an important role in promoting the child's voice in the justice system. This includes seeing the young person on their own so they are able to voice their views and preferences, but also through maintaining (as far as is practicable) a consistent key worker/case manager that is able to support and consider the child's needs.

Resources

Prison and Probation Ombudsman reports

Following any death in custody, the Prisons and Probation Ombudsman holds an investigation to seek to establish the circumstances and events surrounding the death, and provide explanations and insight for bereaved relatives. The investigation examines whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence. If

failings are found, recommendations are made to support improvements. After each investigation, an anonymised fatal incident report is produced, and published following the inquest hearing. These reports can be viewed in the publications section on the Prisons and Probation Ombudsman website.

Serious Case Reviews

Serious Case Reviews (SCRs) are conducted at a local level by the appropriate Local Safeguarding Children's Board (LSCB). They take place after a child dies or is seriously injured and abuse or neglect is known or suspected, or whenever a child dies whilst in custody. The aim of an SCR is to help agencies learn lessons about how they can work better together to protect children. The final reports of SCRs, including the LSCB's response to the findings, must be published. Through collaboration between the NSPCC and the Association of Independent LSCB Chairs, a national repository of published case reviews was set up in England in November 2013.

In Wales this type of investigation would be a Child Practice Review.

Coroner's investigations - Inquests

An inquest is a public inquiry to establish the answers to key questions about a person's death: who the person was, and where, when and how they died. An inquest does not establish any matter of liability or blame. On reaching its conclusion, the Coroner has the additional power to report on circumstances which, if nothing is done, might lead to further deaths and require a response on actions to be taken by the parties the Coroner considers appropriate to take such action. These Prevention of Future Deaths reports and the responses received are all provided to the Chief Coroner, who has the power to make them publicly available.

Deaths of Children in Custody: Action Taken, Lessons Learnt

In February 2014, the YJB published a report describing the thematic learning and the actions that have been taken by the YJB in response to the recommendations directed at the YJB from various investigations into deaths in youth custody between 2000–2007. The report, *Deaths of Children in Custody: Action Taken, Lessons Learnt*, is the first public account of how the YJB has discharged its leadership role by ensuring that we not only act on the recommendations following a child's death, but that we learn from and disseminate across the youth justice system the wider lessons in each case.

Independent Advisory Panel on Deaths in Custody: Information Sharing Statement

In 2011, the Independent Advisory Panel on Deaths in Custody undertook a programme of work that focused on the flow of information through the justice system. As part of this, they developed an Information Sharing Statement reminding of the need to proactively share information to support the assessment and management of risks to safety and well-being.

4. Summary of community safeguarding and public protection incident data

Since 2007, the YJB has required YOTs (as a condition of grant) to report and review serious incidents relating to children and young people under their supervision in the community. In 2013, following a period of consultation, a new system for reporting and reviewing safeguarding and public protection incidents in the community was introduced. This was in response to changes in government policy, the child protection landscape and the emphasis on localism, coupled with the reality of reduced resources at both the local and national level.

This system is called the Community Safeguarding and Public Protection Incidents (CSPPI) process. In developing the new system, there were four key objectives and features to support these, which were:

1. **Secure means of collecting information and data**

   The Youth Justice Management Information System (YJMIS) was adapted to enable YOTs, the YJB's Business Area teams and YJB Cymru to submit secure notifications and reports which could be stored in line with data protection requirements and accessed only by those with a business need to see them.

2. **More consistent processes for reporting incidents**

   A new standard operating procedure was developed, outlining the requirements and flexibilities of the new system.

3. **Means to reduce the burden on YOTs and YJB Business Area Teams which reflected local management and oversight structures**

   The number of incident types where a mandatory notification was required were clarified and reduced. The standard review requirements were streamlined and a template was developed to focus on critical learning. Decisions about the need for and approach to extended learning were now to be made on an individual case basis and with reference to local processes for learning from significant incidents. Quality assurance of reviews was transferred from the YJB to YOTs' own local management structures.

4. **A process to improve local, regional and national learning and understanding to enable the identification of thematic lessons**

   The process introduced a Critical Learning Review template to be completed for each notification. This focused report writers on local, regional and national learning. A system was introduced to enable Business Area teams to share themes and lessons which had national significance and implications.

Following the first year of the CSPPI process being in operation, the YJB undertook a review of the process to identify whether it had achieved the aims identified when it was introduced. Alongside the YJB's own review, an independent review of the process was undertaken by HM Inspectorate of Probation during 2014.[7]

This chapter summarises:

- the data relating to the first two years of the CSPPI process, 2013/14[8] and 2014/15,[9] highlighting any trends or national themes identified from the data and/or YOTs' own learning reviews
- the findings from the YJB's review of the CSPPI process, and identifies next steps.

Data analysis

Summary of data 2013/14

254 safeguarding and public protection incidents were notified to the YJB as having taken place during the reporting period of 2013/14. These incidents were reported by 100 of the 157 YOTs in England and Wales.

177 safeguarding incidents were notified, of which **89%** (n157) met mandatory reporting criteria.

77 public protection incidents were notified, of which **65%** (n50) met mandatory reporting criteria.

77% (n195) of the required number of Critical Learning Reviews were completed and returned, according to the Youth Justice Management Information System (YJMIS). Across YJB Business Areas and YJB Cymru, the return rate for Critical Learning Reviews ranged between 66% and 92%.

There were 22 reports of young people being charged with murder or manslaughter whilst under YOT supervision.

Summary of data 2014/15

213 safeguarding and public protection incidents were notified to the YJB as having taken place during the reporting period of 2014/15. These incidents were reported by 103 of the 157 YOTs within England and Wales.

149 safeguarding incidents were notified, of which **88%** (n131) met mandatory reporting criteria.

64 public protection incidents were notified, of which **75%** (n48) met mandatory reporting criteria.

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[7] HMIP Thematic Review '*An Inspection to Assess the Effectiveness of the Reporting, Monitoring and Learning from the Youth Justice Board's Community Safeguarding and Public Protection Incident Procedures*' published 25 June 2015.

[8] 2013/14 data extracted on 3 June 2015.

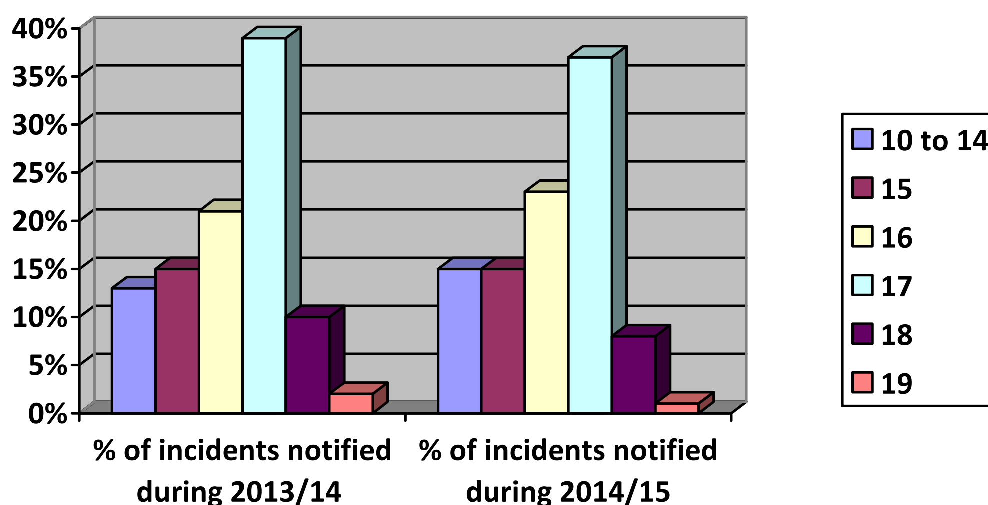
[9] 2014/15 data extracted on 7 July 2015.

79% (n168) of the required number of Critical Learning Reviews were completed and returned, according to YJMIS. Across YJB Business Areas and YJB Cymru, the return rate for Critical Learning Reviews ranged between 50% and 94%.

There were 24 reports of young people charged with murder or manslaughter whilst under YOT supervision.

Notifications[10] predominantly involved young people aged 16 and 17 years, with 60% of notifications involving 16 or 17-year-olds in 2013/14 and 56% of notifications involving 16 or 17-year-olds in 2014/15.

Age of young people at time of reported incidents



Safeguarding incidents

During 2013/14, **70%** (n174) of the notifications received were for safeguarding incidents. In 2014/15, notifications of safeguarding incidents remained roughly at the same level with **70%** (n149) of notifications being safeguarding reports.

In both reporting years, over half of these safeguarding reports related to notifications of attempted suicide (65% (n115) and 58% (n87) in 2013/14 and 2014/15 respectively).

During 2013/14, **37%** (n66) of safeguarding incidents notified involved looked-after children. This was also reflected in 2014/15, during which **48%** (n64) of notifications involved looked-after children.

In addition, **7%** (n12) and **9%** (n14) of safeguarding incidents reported in 2013/14 and 2014/15 respectively involved children who had previously been looked after but were not at the time of the incident. This shows that a disproportionate number of incidents involved a young person who was, or had been, a looked-after child.

Throughout both of the reporting years, whilst overall the majority of safeguarding notifications involved males, safeguarding incidents that fell within the mandatory reporting criteria of 'victim of rape' predominantly involved

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[10] This data relates to mandatory notifications only.

females (96% (n22) of incidents in 2013/14, and 90% (n26) of incidents in 2014/15).

Public protection incidents

During 2013/14, **30%** (n77) of the notifications received were for public protection incidents. In 2014/15, notifications of public protection incidents remained at roughly a third, with **30%** (n64) of notifications being public protection reports.

During 2013/14, **20%** (n15) of public protection incidents notified involved looked-after children. In 2014/15, **23%** (n15) of notifications involved looked-after children.

In addition, **10%** (n8) and **14%** (n9) of public protection incidents reported in 2013/14 and 2014/15 respectively involved children who had previously been looked after but were not at the time of the incident. Again, this shows that a disproportionate number of incidents involved a young person who was, or had been, a looked-after child.

Of all the public protection notifications made during the reporting periods, (77 incidents during 2013/14 and 64 during 2014/15) there was only **one** incident in 2013/14 that involved a female, and **two** incidents in 2014/15.

Markedly, public protection incidents also appeared to indicate a comparatively disproportionate representation of Black and Minority Ethnic (BME) young people over both reporting years. In 2013/14, **50%** of public protection notifications involved BME young people, compared to **12%** of safeguarding notifications. During 2014/15, **47%** of public protection notifications involved BME young people, compared to **13%** of safeguarding notifications.

Discretionary notification of incidents

Of all notifications made throughout 2013/14 to 2014/15, **17%** (n81) were provided on a discretionary basis.

Of the public protection incidents notified on a discretionary basis, these related to a variety of offences with the reasons for reporting falling generally into one of the following categories; incidents where:

- the new charge demonstrated a pattern of offending
- there was local or national media interest in the case
- there was gang or suspected gang involvement in the offending
- the new offences had unusual or ‘newsworthy’ characteristics

Of the safeguarding incidents notified on a discretionary basis, these were almost exclusively in relation to young people who had self-harmed or threatened suicide, but where there did not appear to be risk to life or intent to take it.

Themes and lessons identified within Critical Learning Reviews

The relatively small numbers of incidents[11] and the range of unique factors contributing to them has made it difficult to identify significant themes from Critical Learning Reviews.

However, there were clear areas where concerns from YOTs or examples of good practice can be taken from the Critical Learning Reviews. The following concerns were raised by YOTs in multiple cases as issues that were prevalent and/or difficult for practitioners working with young people in the build-up to an incident:

- difficulties managing breach and/or compliance of young people
- a concerning escalation of problematic behaviour not sufficiently addressed by supporting services
- concerns about parenting ability
- under-estimation of risk, despite contrary evidence
- informal care arrangements and subsequent issues with children going missing. There was a particular link here with the impact on compliance with orders when no formal carer was identified to support the child
- difficulties with family engagement when English was not the first language of parents/carers
- frequent arrests for minor offences not being shared between police and YOTs when no further action was taken
- lack of input from Child and Adolescent Mental Health Services (CAMHS), sometimes despite referrals and regular follow-up
- inability of services to respond to risk of harm to self and others in the same young person

The following examples of good practice were also identified:

- direct YOT work with health commissioners to establish ‘priority pathways’ to provide support for children in the justice system with mental health needs
- protocols for joint working between YOTs and other services
- CAMHS attendance at local gangs forums
- Critical Learning Reviews shared with all agencies involved with the young person to inform release planning and future risk management
- the YOT police officer involved in compliance management for high risk and intensive level cases
- a YOT-wide focus on improving management of cases for looked-after children

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[11] As compared to incident reporting systems across other sectors.

- peer reviewing and the development of a Critical Learning Review gatekeeping tool
- joint ownership of vulnerability plans with Children's Social Care services
- using Short Quality Screening criteria to quality assure Critical Learning Reviews
- sharing learning and reports with the local safeguarding adviser
- organising a conference for agencies to discuss issues and responses to new and emerging drugs

Outcomes of CSPPI reviews and next steps

The objective of the YJB's review of the CSPPI process was to identify whether it had achieved the objectives set out when it was introduced (as identified earlier in the chapter) and whether any changes were required to improve either compliance with the system or the quality of work undertaken within the processes.

The findings of the review are summarised below in response to each of the original objectives:

1. **Secure means of collecting information and data**

   Data collection is more secure than under the previous serious incident reporting system, but YJMIS, the IT platform being used for recording CSPPIs, was not designed for this purpose and is therefore not providing satisfactory support to the job.

2. **More consistent processes for reporting incidents**

   The YOTs responding to the review all had robust systems for identifying qualifying incidents, but discussions with them suggest that there may still be a lack of understanding of reporting criteria. Infrequent use of the process may prevent familiarity with the system developing. It is also worrying that a number of YOTs had made no notifications, with some reporting that problems with YJMIS led to a failure to follow the CSPPI process.

3. **Means to reduce the burden on YOTs and YJB Business Area Teams and YJB Cymru which reflected local management and oversight structures**

   Since the implementation of the new CSPPI process, the time it takes YOTs to complete the Critical Learning Review process has been reduced in comparison to the time taken to complete the previous report in the old system. However YOTs report that it is still time-consuming to review the case files and prepare the information for the report. However, where YOTs have made multiple notifications, skills for drafting the reports have improved and the overall time has reduced. Many YOTs, YJB Business Area Teams and YJB Cymru would favour a system with more detailed input as part of the review's quality assurance and a structured mechanism for sharing lessons learned.

4. **A process to improve local, regional and national learning and understanding to enable the identification of thematic lessons**

   Feedback from YOTs, YJB Business Area Teams and YJB Cymru suggests that the CSPPI system has allowed YOTs to improve their local learning and better target the action they take as a result, but that the flow of local lessons to the centre and the dissemination of national learning has not worked as was planned and needs further development.

The findings of the HMIP thematic inspection are outlined below. This inspection involved visits to 19 YOTs to assess the quality of a sample of 30 Critical Learning Reports completed in response to serious incidents that had occurred over a four-month period in 2014.

Overall, the review considered that YOTs were able to identify qualifying cases and refer appropriately to the YJB. The majority had put a lot of effort into this work and some promising practice was seen. Inspectors also found that:

- more work is required to achieve meaningful learning that can translate into the right actions. In particular:
    - locally the reviews too often failed to incorporate aspects of the child's behaviour and life experiences which could have helped to explain why the serious incident had occurred. As a result, the reviews did not always identify the right lessons to be learnt, which then could not be translated into appropriate action to improve practice
    - nationally the absence of an annual report on trends, good practice and learning is a key criticism of the YJB’s role in supporting learning from incidents in the community. The review highlights that the Critical Learning Report is a significant piece of work for YOTs and they rightly expect to receive an analysis of what all learning from the CSPPI notifications has suggested for practice
- local oversight and quality assurance arrangements were lacking
- YJMIS is ineffective in supporting the system for capturing and monitoring serious incidents. The review concludes that YJMIS does not work properly and results in a high level of frustration and wasted time for all involved.

Next steps

The findings of both the YJB’s own review and the review conducted by HMIP have offered a helpful oversight of how the procedures in place for the notification and reporting of serious incidents in the community operates in practice and the effectiveness of YOTs in reporting, monitoring and learning from the incidents that occur. The findings of these reviews are not dissimilar and have been fully considered in developing our actions in response to all the areas identified for improvement, both where we must lead on and deliver improvements in our own practice and where we can support others to.

We recognise the difficulties with the IT system currently used for reporting serious incidents, the Youth Justice Management Information System (YJMIS). Improvements to the current system are being addressed through the YJB’s Application Strategy that is looking at all the applications in use by the YJB. The

strategy aims to progressively replace the current systems with a new system that meets current business needs, is flexible and adaptable to properly support future business needs, whilst also being cost effective and meeting government and industry technical, security and quality standards. YJMIS was the first application to be considered for improvement and delivery is planned for 2016.

We fully accept the need for a mechanism to bring together key trends, lessons learned and promising practice from safeguarding incidents in the community and secure estate. We will seek to address this by providing an annual report that includes consideration of these factors.

Lastly, changes to support improvements in how the system operates are being taken forward as part of a wider programme of work to review incident reporting and learning processes across the whole youth justice system. Delivery is planned for 2016.

5. Behaviour management in the young people's secure estate

Behaviour management refers to the processes and policies by which youth secure establishments promote positive behaviour and manage challenging and difficult behaviour among young people.

The key themes identified when looking at behaviour management data in custody are:

- use of restrictive physical intervention (RPI)
- self-harm by young people in custody
- assaults involving young people in custody
- single separation in STCs and SCHs

The data presented in this chapter covers the financial years 2010/11 to 2013/14. Within this period, the overall population in youth custody has fallen significantly. This therefore means it is important to look at the change in the rate (i.e. the number of incidents per 100 young people in the population), as well as the raw numbers.

For each type of incident, the total number of actual incidents in the year, the monthly average and the total number of young people involved are presented.

Use of restrictive physical intervention (RPI)

RPIs should only be used on young people as a last resort, for example to prevent them causing harm to themselves or others.

There were 5,714 RPI incidents in the youth secure estate in 2013/14, down by 12% since 2012/13 and 21% from 2010/11.

The number of RPIs per 100 young people increased by 39% between 2010/11 and 2013/14, from 20.5 in 2010/11 to 28.4 in 2013/14. There was also an increase of 19% from 2012/13 (from 23.8 RPIs per 100 young people to 28.4 in 2013/14).

There were an average of 476 RPIs per month in 2013/14, involving an average of 319 young people. The number of RPIs per 100 young people in custody in the year was higher for the younger age group (10-14) and females than their counterparts.

In 2013/14, there were 120 RPIs involving injury to young people. Nearly all (98%) of these were minor injuries. There were 23% fewer injuries to young people following an RPI than in 2012/13.

Self-harm by young people in custody

Self-harm in custody is defined as any act by which a young person deliberately harms themselves, irrespective of the method, intent or severity of the injury. There were 1,318 incidents of self-harm in 2013/14, down by 7% since 2010/11 and down by 8% since 2012/13.

The number of self-harm incidents per 100 young people increased by 62% in 2013/14 compared with 2010/11 (4.1 incidents per 100 young people to 6.6 incidents per 100 young people in 2013/14), and by 25% between 2012/13 and 2013/14 (from 5.2 to 6.6 incidents of self-harm per 100 young people).

There was an average of 110 incidents of self-harm per month in 2013/14, involving an average of 64 young people. The rate of self-harm incidents per 100 young people in custody was higher for females than their male counterparts and for White young people compared to Black, Asian and Minority Ethnic young people.

Assaults involving young people in custody

Assaults are defined as "the intentional use of unnecessary force that results in physical contact with the victim". Physical contact can be by any part of the assailant's body or bodily fluid or the use or display of any weapon or missile. It is not necessary for the victim to suffer injury of any kind. Assaults of a sexual nature are included.

There were 2,932 assaults involving young people in custody in 2013/14, down by 18% since 2010/11 and up by 7% since 2012/13. There was an average of 244 assaults per month in 2013/14, involving an average of 209 young people as perpetrators.

The number of assaults per 100 young people in custody increased by 44% between 2010/11 and 2013/14 (10.1 assaults per 100 young people in 2010/11, compared to 14.6 in 2013/14) and again by 44% compared with 2012/13 (10.1 assaults per 100 young people in 2012/13 compared with 14.6 in 2013/14).

The number of assaults per 100 young people in custody was higher for the younger group (10-14 year olds) and for females.

Single separation

Single separation refers to the confining of a young person in their bedroom, or to another room or area as a means of control, without the young person's permission or agreement, without a member of staff remaining present and with the door locked in order to prevent exit. The data on single separation is only collected for secure training centres (STCs), secure children's homes (SCHs) and private young offender institutions (YOIs).

There were 2,392 occasions where single separation was used in 2013/14, down by 46% from 2010/11 and by 12% since 2012/13. In 2013/14, there was an average of 199 incidents of single separation per month used in SCHs and STCs. This compares to an average of 372 incidents of single separation used per month in 2010/11.

The number of single separation incidents per 100 young people in custody decreased by 40% from 2010/11 to 2013/14 (from 64.5 incidents per 100 young people in 2010/11 to 38.9 in 2013/14). There was a decrease of 9% compared with 2012/13 (from 42.7 incidents per 100 young people in 2012/13 to 38.9 in 2013/14).

The proportion of young people who are placed in single separation while in custody differs by age, with higher rates for the younger group (10-14) and females. There is little difference in single separation by ethnicity.

Implementation of minimising and managing physical restraint

All secure establishments currently report restraint incidents against the definition of RPI and this will continue. However, under Minimising and Managing Physical Restraint (MMPR), establishments are also required to report more detailed data on all uses of force, irrespective of whether they meet the RPI definition or not. This includes the use of MMPR techniques and any use of force that is not an MMPR technique.

Rainsbrook was the first secure establishment to use MMPR, and began doing so from March 2013; data collection under the MMPR system started from this date.

In October 2014, the government published comprehensive MMPR data for the period March 2013 to March 2014. This contained figures from the two STCs, Rainsbrook and Oakhill, and the two under-18 YOIs, Wetherby and Hindley, that started using MMPR during this period. In July 2015, further data was published covering the period April to September 2014.

The data collected includes details on the reason for restraint, protected characteristics of the young people involved and any injuries resulting from the use of restraint. This information is considered both by the YJB and the MMPR National Panel to identify learning on the effectiveness and safety of the MMPR system.

As the data available to date covers relatively short periods of time, there are limitations to identifying any definitive patterns or trends. As more data is collected over a longer period of time, from a greater number of establishments, firmer evidence will emerge.

The most recent update on the behaviour management and restraint work programme was also published in July 2015.

Resources to consider

Local Safeguarding Children's Boards

Local Safeguarding Children's Boards (LSCBs) have a range of roles and statutory functions, including developing local safeguarding policy and procedures, and scrutinising local arrangements. This includes a role in reporting against the use of restraint, and LSCBs are expected to prepare an annual report for the YJB reviewing the use of restraint within any youth secure establishment in their locality.

In 2013, the YJB put together a resource for the Association of Independent LSCB Chairs which provides tips for:

- LSCBs overseeing youth secure establishments
- A child in custody in another area

6. Safeguarding policy, evidence and research

The YJB's approach to safeguarding and child protection

YJB Safeguarding Statement

Our Safeguarding Statement published in 2014 sets out the key responsibilities and commitments the YJB has made in relation to the safety and well-being of children in the youth justice system.

We contribute to the safety and welfare of children in contact with the justice system through the framework of our statutory functions. In particular, we use our good practice and oversight roles to support the youth justice sector in delivering its safeguarding duties.

Our approach is supported by a number of guiding principles, including:

- The **best interests of the child** are a key consideration in decisions taken.
- Safeguarding is **everyone's responsibility**; children's safety is of paramount importance. This is collectively understood and the expectation for everyone to contribute to keeping children safe is clear.
- **Leadership** in promoting best practice to the sector and being **accountable** for the decisions we make, as well as their outcomes.
- **Partnerships**: sharing our knowledge and expertise in the spirit of stimulating reform and being inclusive of others, whilst maintaining relationships with other child-focused stakeholders for the benefit of children and their communities.

We follow these principles in how we take forward our statutory functions by:

- promoting safeguarding approaches and practice throughout the youth justice system
- reflecting on where the gaps are in safeguarding practice and performance across the youth justice system, and how we can develop our own role and support the sector as effectively as possible to address these gaps
- using learning drawn from (amongst others) youth justice providers, children themselves, inspectorates and other investigatory bodies to support monitoring and service development through our dissemination of effective practice

Activities to support the safety and well-being of children

YJB Child Protection Policy

In 2014, the YJB implemented an internal Child Protection Policy to provide staff with guidance and support on how to respond in circumstances when actual or suspected concerns for a child's safety and welfare are raised. It sets out a consistent approach to child protection issues and encourages an understanding of these issues and good practice in addressing them amongst YJB staff.

The expectation is that all staff have a responsibility to act on any information received and to implement the reporting procedure as considered necessary.

We also promote a shared understanding of what constitutes a concern for a child's safety and welfare through mandatory child protection awareness workshops[12] for all staff whose role brings them in contact with children, or involves making decisions that impact on a child's safety and welfare.

YJB Information Transfer Project

The YJB recognises the impact that missing documents have on the safety and well-being of children and young people entering custody. Since June 2012, the YJB has run a project to look at the instances of missing documents and the lack of Connectivity[13] usage by YOTs in the transfer of information at the point of custody. This programme of work has involved tracking missing documentation and following up with YOTs who repeatedly fail to provide documents. This has included engagement and training with the poorest performers.

A review against this programme of work, coupled with the findings from the investigations into the most recent deaths in custody, brought a new impetus to the work and the initial project was re-scoped. The revised 'Information Transfer Project' was launched in April 2014. It provides more targeted support to YOTs, as well as a focus on the quality of the documentation received by the YJB Placement Service, particularly Placement Information Forms, which are the primary documents informing placement decisions.

As part of the project, we also produced guidance for YOTs on how to place young people, recognising that the number of young people receiving custodial outcomes has significantly reduced in recent times.

Since its launch, the Information Transfer Project has been successful in improving the use of Connectivity and the performance of YOTs against missing documents, as the data below demonstrates.

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[12] This awareness programme was initially rolled out during March 2015. It will be refreshed on a three-yearly cycle and supported by annual 'wash up' sessions for new entrants.

[13] A system which allows for migration directly into the eAsset case management system used by the YJB and secure establishments. It should be the standard default method by which information is provided by YOTs to the YJB.

	% Missing Placement Information Forms	% Missing Asset assessments	% Missing Post-court Reports
April 2014	8%	30%	44%
August 2015	4%	21%	28%

Future work by the YJB on information transfer will include:

- identifying and working with YOTs with persistent issues and putting action plans in place
- providing advice, support and guidance to any service through their YJB Business Area team, YJB Cymru or the project team
- working with the YJB AssetPlus team to support transition during deployment

Complaint handling in secure training centres

Children held in STCs can now make complaints to an independent body. The remit of the Prisons and Probation Ombudsman in investigating complaints that have been escalated to them has been extended to children in STCs. This means that, in addition to the current internal complaints process, children in STCs are now able to refer their complaint onwards to the Prisons and Probation Ombudsman.

The role of the Prisons and Probation Ombudsman in investigating fatal incidents in secure children's homes

Since the Children's Home Regulations (for England) came into force on 1 April 2015, the Prisons and Probation Ombudsman now has a role in investigating any death that may occur within a secure children's home (SCH), regardless of the basis for that placement (i.e. whether on justice or welfare grounds).

Further steps are being taken during the coming year to support operationalising this new role in England. In Wales, the extension of the Prisons and Probation Ombudsman's remit to investigate deaths in SCHs in Wales is being considered by the Welsh Government.

Research and guidance

Research summary – interventions and effective practice

Evidence concerning the methods and effect of improving safety in custody or safeguarding in the community unfortunately appears to be very limited. A recent ethnographic study of bullying and victimisation within a custodial environment concluded that tackling victimisation required a 'whole prison' approach and support for both perpetrators and victims. However there seems to be very little evidence about what that support should entail.[14]

The research literature available around both safeguarding and preventing reoffending by children stresses that support needs to be holistic or 'wrap-around', addressing the multiple needs of the child, and with consistent staff who can build a relationship with the child.[15] This has been evident in the learning from investigations into the deaths in youth custody. It is also a key principle of the Welsh *Children and Young People First* strategy, which aims to bring together both justice- and welfare-orientated services.[16]

First annual report: National Panel of Independent Experts on Serious Case Reviews[17]

Most practitioners will be fully aware that the fundamental aims of a serious case review (SCR) are to ascertain what went wrong in the care of a child, when and why it did so, and what can be done to minimise the chance of the same mistakes being repeated.

In 2014, the National Panel of Independent Experts on Serious Case Reviews (for England) produced its first annual report. This concluded that, in many cases, SCRs fail to achieve these aims effectively, due to common key problems. These include:

- the use of irrelevant detail, jargon and acronyms, which make it difficult to discern the key events in the narrative
- reports that repeatedly list what happened without stopping to ask/analyse why. Why were key decisions made? Why were critical observations missed or simply ignored?
- failure to look at human motivation and at the crucial roles played by emotions such as fear, exhaustion, overwork, timidity, wilful blindness and

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[14] Gooch, K. (2015) *Prison Bullying and Victimisation*.

[15] Street, S. (2010) *Safeguarding the Future*; HM Government (2015) *Working Together to Safeguard Children*.

[16] YJB and Welsh Government (2014) *Children and Young People First: Welsh Government/Youth Justice Board joint strategy to improve services for young people from Wales at risk of becoming involved in, or in, the youth justice system*.

[17] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338058/First_annual_report_-_national_panel_of_independent_experts_on_serious_case_reviews.pdf

over-optimism, making it difficult to determine the root causes of critical decisions

- failure to centre on the child or even address the child's perspective
- recommendations which are not clear, focused or addressed to specific individuals or organisations

The independent panel reflected on these failings and identified some features it would expect to see in an effective SCR. These are set out below and offer some points to consider on how these can be applied to learning from serious incidents in the justice system:

- keeping a sharp focus on what caused something to happen and how it can be prevented from happening again
- a concise account of critical points in the management of a case (rather than a lengthy chronology of undifferentiated events)
- a detailed analysis of what went wrong and why, including individual errors and system failures
- clear learning points and recommendations that are appropriately addressed to ensure action. Measures should be included to follow up and see whether these recommendations have been accepted and implemented
- a focus on what the lessons should be for the services concerned, rather than giving an exact account of what happened to a child
- investigations that are proportionate to the case being considered. LSCBs should be looking at a 'sliding scale' of SCRs, from those which result in very quick outcomes and a short report, to those which, by the nature of the incident, require a greater level of investigation
- being prepared to highlight relevant failings and good practice and policy at all levels, not just those at the lower levels

The Department for Education has also recently commissioned a triennial review of SCRs covering the period of 2011–2014. This review will include an analysis of recommendations made in SCRs published during that period, evaluating the extent to which the recommendations reflect the overall learning, whether they are appropriate and achievable, and evidence of the implementation and impact of these. This report is expected in 2016.

Looked after Children and Youth Justice: The Children Act 1989 Guidance and Regulations: Volume 2: Care Planning, Placement and Case Review [Supplement]

This guidance '*Looked after Children and Youth Justice*' is a supplement to Volume 2 of the Children Act 1989 Guidance and Regulations and provides guidance to local authorities in England about their functions under Part 3 of the Children Act 1989.

It has been re-issued following changes in the youth remand framework that came into effect in December 2012 as a result of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, and came into effect in April 2014.

The arrangements outlined in the revised guidance are intended to ensure that looked after children in contact with youth justice services, including those who become looked after as a result of remand, are provided with appropriate support. Their effectiveness will rely on co-operation and partnership between professionals who work in children's services and those working for youth justice services, including those responsible for the care of children in the young people's secure estate.

Working together to safeguard children

In 2015 the Department for Education issued a revised version of the key statutory guidance supporting the safety and well-being of children and young people in England: *Working Together to Safeguard Children* (March 2015). Amongst the key changes was the inclusion of specific youth-justice related elements that support the focus on the needs of children within the youth justice system, particularly custody. The table provided at Annex A sets these out in detail and captures the youth justice content of the guidance more widely. Significantly, these revisions include:

- the impact of the Legal Aid, Sentencing and Punishment of Offenders Act (2012) on the looked-after status of children remanded to custody, and the role of local authority children's services in supporting the needs of this group of children[18]
- the requirement that Local Safeguarding Children's Boards (LSCBs), with youth secure establishments in their area annually report on the use of restraint within these establishments as part of their role regarding improvement activity, and report it to the YJB.[19] Reference is also made to the inclusion of the findings of this annual review within the LSCB's annual report
- the need for LSCBs with secure establishments in their area to consider how the thresholds they apply and their criteria for referral and assessment take account of the context of the needs of children and young people within the secure estate[20]
- the timing of the publication of Serious Case Reviews (SCRs) needing to have due regard to the impact on any ongoing legal proceedings, including any inquests

Changes to the Children's Commissioner's role and remit in England

The Children and Families Act 2014 reformed the Children's Commissioner's statutory role. The Children's Commissioner now has a legal duty to promote and protect children's rights. The Act also says that in carrying out their work, the Children's Commissioner must have particular regard to children living away from home, receiving social care and other groups they consider at risk of having their rights infringed.

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[18] See page 20, para 34, and page 101 of *Working Together to Safeguard Children* (HM Government, 2015).

[19] See page 73, para 9, of *Working Together to Safeguard Children* (HM Government, 2015).

[20] See page 16, para 18, of *Working Together to Safeguard Children* (HM Government, 2015).

NSPCC: How safe are our children? (2015)

The annual 'How safe are our children?' report was published by the NSPCC in July 2015. It provides the most robust and up-to-date child protection data that exists across each of the four nations in the UK.

The report sets out 20 different indicators. Each indicator looks at the question of "how safe are our children?" from a different perspective. It also includes a section summarising the factors that influence a child's risk of abuse or neglect. The report identifies some key findings:

- the most serious forms of physical abuse such as homicide and deaths by assault remain down and have been steadily falling
- there is an increased willingness to speak out about abuse and neglect. Contacts to the NSPCC helpline increased again during 2013/14 compared with the previous year
- the number of children on child protection registers and protection plans continues to increase in England, Wales and Scotland. As does the number of children who are looked after due to abuse or neglect in England and Wales
- more support is needed for the victims of abuse. There has been a rise in the number of people coming forward about their experiences of abuse. The support must match this increased willingness to speak out. Victims of child abuse need more therapeutic support, and age-appropriate support at every stage of the criminal justice process
- neglect remains the most common form of child abuse across the UK
- early intervention is key. Intervening early to address problems before they become more serious and entrenched is the most effective approach

ChildLine Annual Review

The recently published ChildLine annual review 2014-15, "*Always there when I need you*", has highlighted some shifts in the emerging issues that children and young people are contacting ChildLine to talk about.

ChildLine provided nearly 290,000 counselling sessions to children and young people over the last year at all times of day and night by phone, email and one-to-one online chat. The top three concerns counselled were family relationships, low self-esteem/unhappiness and abuse. Alongside this, they found that four of the top ten issues expressed related to mental health, accounting for almost a third of total concerns. The report also identifies the recurring issue of bullying as a persistent factor in many young people's lives.

7. Next steps

We consider that learning and actions to make the youth justice system safer for children and young people must be a continuous process. We have already begun to make changes in response to the lessons and recommendations from investigations into the deaths during 2011/12. We have identified areas of further work, including:

- the care and support of looked-after children
- reducing bullying and its impact in the secure estate
- listening to children and acting upon what they say
- continuing to improve information-sharing
- understanding how to better support children at risk of self-harm or suicide

Delivering improvements to the safety and well-being of children in the youth justice system will continue to be the focus of activities going forward.

In 2016, we will introduce an improved incident reporting process for the community and secure estate. We are also working closely with the Ministry of Justice, our providers and key stakeholders to ensure that what we know and have learnt about keeping children safe in the secure estate is embedded in plans for the future. This includes developing the YOI sector, specifically enhancing the management of self-harm and suicide, and informing the more wide-ranging Youth Justice Review being carried out by the Ministry of Justice.

Over the next couple of years, we will see AssetPlus, the new assessment and planning interventions framework, deployed and embedded. This will allow one assessment record to follow a child or young person throughout their time in the youth justice system, both during their time in the community and any period spent in custody. It will facilitate better information sharing, particularly between agencies once a young person has been sentenced or remanded to custody.

We anticipate that the focus of much safeguarding and child protection related work will continue to be shaped by concerns related to child sexual exploitation. Research shows that links can exist between those children who have been victims and survivors of sexual abuse or exploitation and incidents of their offending behaviour.

The YJB has always actively supported work to identify and prevent child sexual exploitation resulting from harmful sexual behaviour by adults or by other young people, as outlined in *The role of the Youth Justice Board in preventing child sexual exploitation and harmful sexual behaviour*. Through strategic work, we will continue to support activities to tackle child sexual exploitation and abuse.

In 2015/16, the YJB also set out a work plan to specifically consider the over-representation of Black and Minority Ethnic (BME) young people in the criminal justice system. As a recognised cross-cutting theme, some of the related project strands will enable further consideration to be given against areas which are linked to safeguarding concerns. This will include:

- the impact of the over-representation of BME groups within the looked-after children cohort, which are in turn also over-represented within the youth justice system
- the use of separation and restraint
- the application of rewards and sanctions (among other areas)

We will consider what we learn about disproportionality and the most appropriate actions in response. The YJB is also part of the Young Review[21] Advisory Group and will continue to support this and feed in information specific to BME young people.

The YJB recognises the significant overrepresentation of looked after children in the youth justice system. We welcome the Prison Reform Trust's inquiry, *Keeping Children in Care Out of Trouble*, which is being chaired by Lord Laming. Its remit is to better understand the reasons behind the overrepresentation of this group in the youth justice system, and ways of effectively address this. As a member of the steering group, we have actively contributed to the review and will seek ways to best support its findings and recommendations.

Additionally, we are focused on how to influence practice and emphasise the need for specific care and support for looked after children, both in custody and under YOT supervision in the community. We have already begun to engage with key partners such as Local Safeguarding Children's Boards (LSCBs) and the Association of Directors of Children's Services, to raise awareness among LSCBs and local authorities about the specific safeguarding issues associated with children in the youth justice system. We will continue to emphasise this need and to encourage the engagement of youth justice practitioners to support this.

The coming year will also see the implementation of the Social Services and Well-Being (Wales) Act 2014 in Wales. This will bring about key changes for the role of Welsh local authorities in assessing the needs of children and young people in the youth justice system and considering the pathways for those in custody who may have care and support needs. The YJB will actively assist the implementation of this.

In July 2015, Lord Harris' *Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 Year Olds* was published. The YJB welcomed the review and its findings. Although these focused on the young adult secure estate, they powerfully advocate the benefits of a multi-agency and holistic approach to address the needs of those in the criminal justice system; to reduce the use of custodial sentences; and to rehabilitate those who are serving them. The findings reflect the multidisciplinary approach that has been used by youth justice services, which has been key to the success in reducing the numbers of young people in custody, and of first time entrants into the youth justice system, to their lowest ever levels.

[21] The Young Review (December 2014) outlines the experiences and needs of Black and Muslim men aged 18-24 in the criminal justice system and makes recommendations in response.

We have begun, and will continue to, consider carefully where, and how, the well-informed recommendations could also apply to the care of children and young people in custody and have also continued our efforts to improve transitions between youth and adult justice services.

The safety and welfare of children in the youth justice system is a shared aim of all those working within it, both as a goal and as a duty. As we look towards the future and the challenges ahead, achieving this in a way that supports, rehabilitates, but, above all, keeps young people safe, must continue to be the focus.

Annex A: An outline of contents specific to youth justice from the Department for Education's statutory guidance, 'Working Together to Safeguard Children' (2015)

Reference	Text as it appears in 'Working Together' (2015)	Comments (application to the youth justice sector)
Page 11, Para 23	"…local agencies need to have a clear understanding of the collective needs of children locally when commissioning effective services. As part of that process, the Director of Public Health should ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the health and well-being board."	This may offer youth offending teams (YOTs) and their management boards a lever in accessing services for children and young people under YOT supervision.
Chapter 1: Assessing need and providing help		
Page 13, Paragraph 4	"Training should cover how to identify and respond early to the needs of all vulnerable children, including: unborn children; babies; older children; young carers; disabled children; and **those who are in secure settings**."	Specific reference is given here to the secure estate when outlining the need for LSCBs to monitor and evaluate the effectiveness of training for professionals with regard to safeguarding.
Page 16, Paragraph 18	"LSCBs with youth secure establishments in their area should ensure that thresholds and criteria for referral and assessment take account of the needs of young people in these establishments."	A specific reference is now included regarding the need for LSCBs with secure establishments in their area to consider how the thresholds they apply and their criteria for referral and assessment take account of the needs of

		children and young people within the secure estate.
Page 20, Paragraph 34 Reinforced through the text at Annex B re the statutory framework (page 101)	"Where a child becomes looked after as a result of being remanded to youth detention accommodation (YDA), the local authority must visit the child and assess the child's needs before taking a decision. This information must be used to prepare a Detention Placement Plan (DPP), which must set out how the YDA and other professionals will meet the child's needs whilst the child remains remanded. The DPP must be reviewed in the same way as a care plan for any other looked after child."	Recognises the impact of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 on the looked-after status of children remanded to youth detention accommodation and the local authority's responsibilities for them as a looked after child.
Page 22, Paragraph 38	"Assessments for some children – including young carers, children with special educational needs (who may require statements of SEN), unborn children where there are concerns, asylum seeking children, children in hospital, disabled children, children with specific communication needs, children considered at risk of gang activity, **children who are in the youth justice system** – will require particular care."	Specific reference is given here to the requirement for assessments to consider the needs of children and young people in the youth justice system and the co-ordination of these assessments between agencies.
Page 27, Paragraph 67	"Local protocol for assessment should: • set out how the needs of disabled children, young carers and children involved in the youth justice system will be addressed in the assessment process;"	The assessment needs of children in the youth justice system are specifically referenced with regard to local protocol arrangements and how cases will be managed once referred into local authority children's social care services.
Chapter 2: Organisational responsibilities		
Page 52, Paragraph 3	"Section 11 places a duty on: [includes] • Governors/Directors of Prisons and Young	Organisations bound by section 11 duties are required to ensure the functions and services

	Offender Institutions • Directors of Secure Training Centres; • Principals of Secure Colleges and • Youth Offending Teams/Services."	they discharge have regard to the need to safeguard and promote the welfare of children. *Decisions taken following the 2015 General Election mean that the reference to the 'Principal of Secure College' is now unnecessary.*
Page 53, Paragraph 4	"These organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including: • a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. **Designated professional roles should always be explicitly defined in job descriptions.** Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively; [amongst others]"	The reference to ensuring that a designated professional lead is in place amongst the organisations bound by Section 11 reinforces the YJB's ability to require this clarity in the safeguarding arrangements of our providers.
Page 57, Paragraph 17	"NHS England is responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is also accountable for the services it directly commissions, including health care services in the under-18 secure estate and in police custody."	Specific reference is given here to the responsibilities of NHS England concerning the needs of children in the secure estate. (For those children and young people accessing youth justice services in the community, a reference is made in the guidance at Annex B, page 101, with regard to the role of Clinical Commissioning Groups in securing youth justice services in their area, connected to the Crime

		and Disorder Act 1998.)
Page 58, Paragraph 19	“[Police responsibilities] Children who are encountered as offenders, or alleged offenders, are entitled to the same safeguards and protection as any other child and due regard should be given to their welfare at all times”	This point reinforces the safeguarding needs of children who are perpetrators of crime, as well as those who are victims.
Page 59, Paragraph 25	“Housing authorities also have an important role to play in safeguarding vulnerable young people, including young people who are pregnant, leaving care or a secure establishment.”	This reinforces the duties on Housing Authorities with regards to safeguarding and that this equally applies to young people leaving secure establishments. This ties in to the importance of accommodation to resettlement.
Page 61, Paragraph 34 - 35	“Governors, managers, directors and principals of the following secure establishments are subject to the section 11 duties set out in paragraph 4 of this chapter: • a secure training centre; • a young offender institution; • secure children’s homes, namely children’s homes approved by the Secretary of State for accommodating children and young people who require the protection of a secure setting; and • a secure college. “Each centre holding those aged under 18 should have in place an annually reviewed safeguarding children policy. The policy is designed to promote and safeguard the welfare of children and should cover all relevant operational areas as well as key supporting	This sets out the organisational responsibilities of establishments within the youth secure estate under section 11. *Decisions taken following the 2015 General Election mean that the reference to ‘a secure college’ is now unnecessary.*

	processes, which would include issues such as child protection, risk of harm, restraint, separation, staff recruitment and information sharing. A manager should be appointed and will be responsible for implementation of this policy.”	
Page 62, Paragraph 36 - 37	“Youth Offending Teams (YOTs) are subject to the section 11 duties set out in paragraph 4 of this chapter. YOTs are multi-agency teams responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. They are therefore well placed to identify children known to relevant organisations as being most at risk of offending and to undertake work to prevent them offending. YOTs should have a lead officer responsible for ensuring safeguarding is at the forefront of their business. “Under section 38 of the Crime and Disorder Act 1998, local authorities must, within the delivery of youth justice services, ensure the ‘provision of persons to act as appropriate adults to safeguard the interests of children and young persons detained or questioned by police officers’.”	This sets out the organisational responsibilities of YOTs in terms of their section 11 duty and their role in providing Appropriate Adult services to children in police custody.
Chapter 3: Local Safeguarding Children’s Boards		
Page 68	“Board partners who must be included in the LSCB are [among others]: • the Youth Offending Team • the governor or director of any secure training centre in the area of the authority; and	This sets out the youth justice organisations who are bound by section 13 as statutory members of the Local Safeguarding Children’s Board (LSCB).

	• the governor or director of any prison in the area of the authority which ordinarily detains children."	
Page 70, Paragraph 18	"Where the LSCB has a secure establishment within its area, the [annual] report should include a review of the use of restraint within that establishment and the findings of the review should be reported to the Youth Justice Board."	A requirement for LSCBs to consider the use of restraint in secure establishments in their area annually and provide the YJB with a report of their findings.
Chapter 4: Learning and Improvement Framework		
Page 73, Paragraph 9	"Where the LSCB has a secure establishment within their area this improvement activity should include an annual review of the use of restraint within that establishment and a report of findings to the Youth Justice Board."	The reference here is made specifically with regard to the improvement activity LSCBs undertake and that their review of the use of restraint within the youth secure estate should be considered part of this improvement activity.
Page 76, Paragraph 19	"…even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing"	With regard to the definition of serious harm, *Working Together* is clear that even if only one of the criteria are met, where a child dies in custody a Serious Case Review must always be conducted.
Page 80	"When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders. The timing of publication should have due regard to the impact on any ongoing legal proceedings, **including**	The specific reference to the inquest process was inserted to respond to cases where the death of a child has occurred in youth custody and a number of investigations and reviews are occurring alongside each other. Given the experience of this with regards to the most recent deaths in youth custody during 2011/12, it is hoped that this will provide clarity on the requirement to publish the SCR but ensure that the timing of this does not impede the other

	any inquest."	investigations that will also be underway.
	Chapter 5: Child Death Reviews	
Page 87, Paragraph 19	"Youth Offending Teams' reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP child death processes."	*Working Together* considers the responsibilities of local authorities around notifiable incidents. Youth offending teams report significant incidents to the YJB via the Community Safeguarding and Public Protection Incidents (CSPPI) system. We are keen to see the requirements upon YOTs through this system aligned with the local authority's overall responsibility for ensuring that YOT practice in this regard is adequate and that learning is properly actioned and shared. The reference here however only specifically mentions the Child Death Reviews.
Page 87, Paragraph 21	"…for any child who dies in a secure children's home, the Prisons and Probation Ombudsman will carry out an investigation. In order to assist the Ombudsman to carry out these investigations, secure children's homes are required to notify the Ombudsman of the death and to comply with requirements at regulation 40(2) of the Children's Homes (England) Regulations 2015 to facilitate that investigation."	This reinforces the recent change to Children's Homes Regulations (which came into force in April 2015) to ensure that the Prisons and Probation Ombudsman is notified of any death in a secure children's home, provided access and supported to carry out their investigation by the secure children's home.