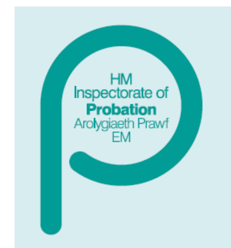
An overview of inspection findings

An overview report of the inspection findings from Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons in relation to the help, care and protection of children.



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Introduction

1. The Office for Standards in Education, Children's Services and Skills (Ofsted) the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation (HMI Probation) and Her Majesty's Inspectorate of Prisons (HMI Prisons) are committed to the introduction of a targeted programme of integrated inspections of the arrangements to help, care for and protect children in England.

2. In 2012, the inspectorates consulted on proposals for the development of inspections in two key areas of children's services: multi-agency arrangements for the protection of children, and services for children and young people looked after and care leavers. The former was a joint consultation between all the inspectorates and the latter between Ofsted and CQC. The learning from the pilots associated with these inspections and the concerns expressed by local authorities through the Society of Local Authority Chief Executives (SOLACE), the Association of Directors of Children's Services (ADCS) and the Local Government Association (LGA) regarding the use of a shared judgement of a complex multi-agency system, led to Ofsted taking the decision to defer the multi-agency inspection of child protection and instead commence a targeted child protection inspection programme. In parallel, the framework for the inspection of services for children in need of help and protection, children looked after and care leavers (single inspection framework) and reviews of Local Safeguarding Children Boards (launched in November 2013) were developed by Ofsted.

3. All partner inspectorates have continued to evaluate the effectiveness of agencies and settings in respect of the help, care and protection of children and young people. This report brings into one place, the findings of the five inspectorates from their own single inspection activity in the intervening period since the deferment of multi-agency inspections. This report is being published alongside the shared consultation on the arrangements for integrated inspection to be implemented (as a targeted programme) from April 2015. The consultation document can be found at: www.ofsted.gov.uk/resources/140112.

Chapter 1: Ofsted

Inspections of local authority services for children in need of help and protection, children looked after and care leavers

4. On making the decision to defer the multi-agency inspections, Ofsted began a universal three-year cycle of inspections of local authority services for children in need of help and protection, children looked after and care leavers. This replaced the previous inspections of child protection, services for looked after children and the inspections of local authority fostering and adoption.

5. The Ofsted 'single inspection framework (SIF)'[1] implemented in November 2013, focuses on the effectiveness of local authority services, arrangements to help and protect children, the experiences and progress of children looked after, including permanence for them, adoption, fostering, the use of residential care and the experiences of children who return home. It also examines the experiences and progress of care leavers.

6. Of the first 17 SIF inspections, six have received an overall judgement of 'good'; eight are judged to 'require improvement and three have been found to be 'inadequate'.

Good local authorities

7. In the strongest local authorities, it is encouraging that Ofsted inspections has identified clear evidence of 'good' help for families alongside effective protection and care for children. The engagement of children and young people is also prioritised and their voices and experiences are relentlessly sought in the help they are offered.

8. In these places, early help extends beyond strategic intent. Inspectors find services and professionals from schools, health services, police and the voluntary sector are woven into an 'early offer' for families. These services are known and they make a difference.

9. Assessments that are completed are consistently good. They identify risks, needs and clear next steps with timescales. The capacity of parents to change is well expressed in records and there are explicit objectives in plans about what has to be achieved by parents and carers in respect of protecting and caring for their children. Plans further make clear the consequences of no change and in the most effective local authorities, non-compliance equates to decisive and well-informed action to protect children quickly. Chronologies in these cases are well established and provide an on-going cumulative picture of

[1] These inspections are conducted under section 136 of the Education and Inspections Act, 2006: www.legislation.gov.uk/ukpga/2006/40/section/136.

the experiences of children. This clearly supports good decision making in their best interests.

10. What is striking in the local authorities judged to be 'good', is the centrality and importance of direct work with families. They report having stable relationships with social workers and there is consistent case file evidence showing that assessment is derived from on-going and regular contact housed in a relationship that is firmly established between the worker and the family. This contrasts directly with weaker practice, where assessment is conducted as a single exercise dominated by forms. It is a means in itself, often characterised by several disconnected separate attempts at assessing. In the strongest places, it is very clearly constructed from knowledge and continuous engagement with the adults and children it concerns. In these cases again, inspectors find that there is usually a theoretical framework informing professional practice, giving staff more confidence and enabling consistency in the work that they undertake with families.

11. When children require protection in stronger local authorities, it is clear that action is taken in their best interests and quickly. Legal decisions are consistent and legal advisers are able to work closely with social workers. Cases are supported in the courts. Looked after children are making more progress in school than in less effective local authorities, where their achievement is not so closely monitored or prioritised.

12. Inspectors find also that, in the good local authorities, permanent new homes are found more quickly for children who are looked after; in one local authority, the time taken from approval to matching is typically three months. There are more placements to enable children to live with brothers and sisters.

13. Lastly, in 'good' local authorities, Ofsted is finding that investment in the professional environment enables social work to flourish. Workloads are understood, closely monitored and management oversight pivots on quality as well as volume. Vacancies are reviewed and leaders have local knowledge and strategies about how to retain and attract new staff. Supervision and training are effective and managers know the children and care plans well. Principal social workers influence practice and provide the professional voice in senior management teams.

14. Strengths and weaknesses are known by leaders (politicians too) and critically there is an action plan in place that benefits from strong performance management and prioritisation of both resource and oversight. Learning forms the foundation for these plans.

15. Ofsted also reviewed the characteristics of local authorities being awarded the new judgement of 'requires improvement'. There are two distinct differences in the inspection evidence that has been examined:

- the quality of professional practice at the frontline and the effectiveness of decision making in respect of help, care and protection are far more variable
- the quality, specificity and oversight of the processes to support the child protection and care systems are less robust and contribute to less good experiences for children, young people and families.

16. Multi-agency work and professional participation in basic protective activity is highly variable, and this has a significant impact on the quality of assessment, the understanding of risk and timely agreement about next steps. In real terms, this is often visible in professional absence from child protection strategy meetings, case reviews, case conferences and attendance at LSCB meetings.

17. There is an associated body of evidence in these places, of less consistency and greater inflexibility about protection and care thresholds. Reports describe higher thresholds and children not receiving help when they need it. The 'meeting' of threshold criteria in some instances is more dominant than the seeking of an understanding about what is needed and whether it can be provided. The risks to families where help is not available is considered less often.

18. Significantly, where a judgement of 'requires improvement' is given, inspectors find evidence of Section 20 of the 1989 Children Act[2] being deployed for children where the threshold of significant harm is met and therefore Section 31[3] should apply.

19. Other themes emerging in local authorities where performance is judged to be weaker, include the cessation of help too early for families, less rigorous or delayed action where children remain at risk of harm and plans that are not specific in either action to be taken or the changes that need to take place. Management oversight is less persuasive and in almost every local authority judged to 'require improvement', workloads for social workers are too high, making it impossible for them to do their jobs effectively. In some places, the impact is already being seen in less stable staffing, where turnover directly compromises the quality of relationships that workers can have with families.

20. Performance is not monitored strongly and often volume is measured in place of quality and impact. Children's voices are present but faint in the system as is their attendance at conferences and reviews. For children who are looked after, the sufficiency strategy does not provide well for their needs and placements are in short supply.

[2] www.legislation.gov.uk/ukpga/1989/41/section/20.
[3] www.legislation.gov.uk/ukpga/1989/41/section/31.

Reviews of Local Safeguarding Children's Boards

21. Alongside the local authority inspections, Ofsted introduced the separate reviews of Local Safeguarding Children's Boards (LSCBs) in November 2013.[4]

22. The evidence supporting the reviews of LSCBs, finds that those judged to be 'good' are characterised by clarity of responsibility among the chair, the director of children's services and the chief executive. This clarity and visibility extends to connectivity with local decision makers, particularly health and well-being boards and clinical commissioning groups. Priorities and resources (to enable the board to carry out its functions) are more likely in stronger LSCBs to be shared among partners. Inspectors see evidence of boards being able to influence shared investment in initiatives to support families before formal social care services are required.

23. The defining characteristics of 'good' LSCBs, include a focus on practice, both through section 11 audits that are mature and which continually develop around new priorities and challenges, for example the sexual exploitation of children and the training that is developed for all staff. Learning from practice is evident in areas with effective LSCBs where case audits show that practice at the frontline across a range of multi-disciplinary services, changes and improves.

24. In those areas, where the LSCB is judged to 'require improvement', inspectors find that priorities are often newly expressed and not yet integrated into the business of the boards. Scrutiny of and practice challenge, tends to be agency specific, neither being undertaken collaboratively or at the interfaces of service boundaries where the needs of children are often acutely in view but responsibilities unclear. Partners are less engaged with the board and with each other and they are not able to provide sufficient evidence about accountabilities, for example in the cases of children missing from home or care. The quality of practice is less well prioritised by weaker boards. Inspectors find less evidence of practice audit overview and limited monitoring by the board of progress against agreed priorities. Boards are also making less use of performance data to support them in their function of monitoring and evaluating the effectiveness of what is being done by the local authority and partners to help, care for and protect children. Whilst learning from practice is in evidence, it is often about structures and not the practice of protection and care.

25. The emerging theme in respect of boards that are effective and those that are less so, relate to the extent to which partners are able to hold each other to account at the highest level for poor or stagnant practice. The reviews, show that stronger boards, are able to use their clearer lines of accountability and

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[4] These reviews are conducted under section 15A of the Children Act 2004: www.legislation.gov.uk/ukpga/2004/31/section/15.

responsibility to challenge and to co-ordinate change and improvement. They are also clearer about their role as set out in the Children Act 2004 'to ensure the effectiveness of what is done by each person or body for the purposes of protecting children and promoting their welfare'. Their activity and priorities clearly delineate the boundary between operational delivery (for which the board has no responsibility) and the evaluation of the effectiveness of all statutory partners in protecting and caring for children and young people.

26. Ofsted remains firmly of the view that the reviews of LSCBs are identifying opaque accountabilities that are not made clearer by statutory guidance or the regulations setting out the functions of LSCBs.

27. We intend to further evalulate the evidence from the reviews with a view to having further discussions with the Association of Independent LSCB Chairs, local authorities, chief executives and the Department for Education about ways in which authority, independence and accountability for the care and protection of children and young people can be properly exercised.

Care Quality Commission

Chapter 2: The Care Quality Commission

Children looked after and safeguarding reviews

28. These initial findings are taken from the first twelve reviews conducted October 2013 to February 2014. These were a mixture of high to medium risk and spread over the country. Initial findings are as follows:

Overall strengths

29. Designated doctors and nurses for looked after children are effectively monitoring health plans and ensuring children and young people are getting access to the health services they need.

30. There is a significant improvement in the engagement of GPs in child protection conferences and evidence of good quality and prompt information sharing by GPs when they have had concerns.

31. There is an overall increased awareness of the role of GPs in safeguarding.

32. The roles of named and supervisory midwives is improving the effectiveness of services provided to vulnerable pregnant women.

33. Pathways for pregnant teenagers are being implemented, effectively supporting this vulnerable group.

34. Information sharing between children/young persons drug and alcohol services and appropriate partner agencies is well embedded and effective.

35. The paediatric liaison role in acute settings is significantly improving the identification and sharing of safeguarding concerns.

36. Flagging systems are in place to identify those children on a CP plan or who are looked after, and who has parental responsibility. Practitioners are increasingly recording the details of adults who accompany children to emergency departments.

37. Supervision of staff is well developed and is in line with the inter-collegiate professional requirements and monitored by the LSCB in most areas.

Overall weaknesses

38. The collection and analysis of comprehensive data on the health of looked after children is under-developed.

39. There are insufficient commissioning, governance and assurance arrangements to provide effective scrutiny of health services provided to children and young people who are looked after.

40. Care leavers are not being provided with comprehensive summaries of their health histories or information about contact details should they need to re-engage with the looked after children's health team.

41. There is a lack of service provision for those young people who are transitioning from children's to adult services. This is particularly evident for young people in transition from CAMHS with on-going emotional health needs who are unlikely to meet thresholds for adult services.

42. There is insufficient in-patient mental health provision (tier 4) capacity to enable young people to have timely access to specialist care when they need it.

43. There is insufficient tier 3 provision and community based alternatives to in-patient care to facilitate care closer to home.

44. Children and young people with emotional, mental health and behavioural needs are experiencing delays in accessing the help and support they need.

45. Data management systems are not always secure, up to date, and compatible with each other in order to enable transfer and follow up of concerns between local organisations.

46. Alert systems are not updated with timely and accurate information about risks to children, including children on child protection plans and those who are looked after; or consistently used by frontline health staff to identify and report concerns.

47. There is ineffective partnership working to ensure that unborn babies, who have been identified as at risk, have the protection of multi-agency involvement in early assessments or timely child protection case conferences.

48. There is a wide variation in the levels of paediatric trained medical and nursing staff in urgent care centres, and not all children are being cared for by appropriately trained staff with updated specialist paediatric skills and assessed competencies.

Areas for improvement

49. Recommendations have been made to improve the quality of health assessments, many of which are incomplete and of a poor quality. Information relating to the use of strengths and difficulties questionnaires or other evidence based tools to monitor the emotional and mental health of looked after young people, is poorly explored or missing. In addition, health assessments are not supported by a health plan that sets out clear and measurable health objectives

for the child and identifies those accountable for the delivery of outcomes within defined timescales.

50. Safeguarding referrals made by health practitioners to children's social care, are of variable quality and, in particular, fail to articulate clearly the risk to the child/young person. Recommendations have been made to address this.

51. The capacity of the family nurse, teenage pregnancy midwives and the sexual health outreach workers in some areas needs to be increased to effectively meet current levels of demand.

52. Gaps in perinatal mental health services need to be identified and addressed in order to deliver improved outcomes for women and their babies.

53. The safeguarding roles and responsibilities of GPs need to be discharged effectively and to a consistent standard in all areas.

54. Improvements need to be made in the assessment of children and young people's misuse of drugs and/or alcohol so that appropriate help and intervention can be given.

55. Adult mental health practitioners are not engaging consistently with relevant partner agencies where children are subject to child in need and child protection plans. In addition, practitioners need to ensure they are recognising and safeguarding the needs of children within families who are affected by mental illness.

56. There are ineffective or inconsistently applied discharge arrangements from urgent care, minor injury units and emergency departments where information is not shared with appropriate professionals and risks to children and young people are not being identified or properly followed up. Recommendations have been made to improve information sharing and discharge arrangements where these are weak.

57. Intercollegiate standards and NICE guidance for safeguarding and looked after children including training, supervision and quality assurance requirements are not being consistently met. Recommendations have been made to ensure compliance with these standards.

Inspecting policing in the public interest

Chapter 3: Her Majesty's Inspectorate of Constabulary

Child protection inspection findings

58. Between October 2011 and March 2013, Her Majesty's Inspectorate of Constabulary (HMIC) conducted a number of child protection inspections of police forces across England and Wales as part of the development of the Ofsted led multi-agency child protection inspection programme. Further ad hoc child single-agency child protection inspections were carried out between March 2013 and December 2014. Reports from these inspections are published on the HMIC website.

59. HMIC commenced the implementation of its single National Child Protection Inspection Programme of all police forces in England and Wales in April 2014.

60. We have set out below the key themes that have emerged from those child protection inspections to date.

Strengths

61. Child protection is a priority for police forces. All forces we inspected had a senior police officer with responsibility for child protection. Most forces had provided their uniformed staff with training on child protection. This training highlights the risks that children can face and the responsibilities of police officers and staff in assisting in the identification and protection of children at risk of harm.

62. Staff whose responsibility it is to manage child abuse investigations are knowledgeable and committed to providing good outcomes for children.

63. The police forces inspected were aware of the significance of information about missing children. They use it as a potential indicator of children being at risk of harm. Information was shared with key local partners including children's social care (CSC). In the majority of forces, multi-agency groups had been established to help and protect children identified as being at potential risk of harm.

64. All forces inspected had well trained and supported specialist child protection officers. All staff had either completed the Initial Crime Investigator Development Programme (ICIDP) and the Specialist Child Abuse Development Programme or were in the process of doing so.

Areas for improvement

65. It is not always clear that officers attending domestic abuse incidents check to ensure that any children present are safe and well. This is a minimum requirement for child protection and should be undertaken on every occasion. Safe and well checks are not always recorded on police incident logs.

66. Information gathered by officers attending domestic abuse incidents rarely includes an indication of how children in the household are affected. This is important information that assists CSC and other local partners to determine the risk that a child may be facing and the action that may be needed to protect them.

67. In the majority of police forces, officers do not always recognise the potential risks faced by children in domestic abuse incidents where the victim is assessed as being at risk of serious harm. In those situations, strategy discussions are not routinely conducted with CSC and other local partners to consider if a Section 47 enquiry is required to determine the help and protection needed by the child or children.[5]

68. Relevant background information available from police information and intelligence systems is not included on many referrals or notifications sent to CSC. This information is necessary to enable CSC and other partners to assess the risk of harm to children and to determine the level of help and protection they should receive.

69. Recording of strategy discussions, which form part of Section 47 enquiries, is inconsistent. In some cases, there is no record of discussions. In others, there is little clarity about what has been discussed and what decisions have been taken. Section 47 enquiries are an integral part of effective child protection. Properly recorded strategy discussions are crucial to establish what action will be taken to protect children and to hold agencies responsible for that action to account.

70. The number of children denied bail after charge who continued to be detained in police custody is a cause for concern in the majority of forces. Alternative accommodation options are not fully explored, for example non-secure local authority accommodation. In many force areas this issue is not fully understood and there is a lack of strategic partnership oversight to ensure appropriate provision for children.

71. Children who are detained in police custody pre-charge can experience unnecessary delays in having access to an appropriate adult. Children may also spend significant periods of time in police custody without contact from anyone other than police custody staff.

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[5] Enquiries are conducted under Section 47 of the Children Act 1989 to determine what action should be taken to protect children and young people who are found to be suffering, or likely to suffer significant harm: www.legislation.gov.uk/ukpga/1989/41/section/47.

Chapter 4: Her Majesty's Inspectorate of Probation

Protecting children thematic inspection: emerging themes

Scope and purpose

72. Her Majesty's Inspectorate of Probation (HMI Probation) strongly supports the principle of multi-agency inspection and participated in the development of the original multi-agency inspection arrangements. Following the deferral of that programme, HMI Probation has completed a thematic inspection on child protection arrangements in Probation Trusts and Youth Offending Teams. In addition, child protection has been the topic in the most recent round of performance inspections of Probation Trusts. The thematic report and the aggregate findings of the performance inspection of Probation Trusts will be published in summer 2014.

73. This paper describes some of the emerging trends we identified in our thematic inspection carried out between September and November 2013. The findings are provisional and may be subject to revision; as such they should be treated with caution pending the publication of the thematic report.

74. We visited six areas in England and Wales and assessed cases held by Probation Trusts and Youth Offending Teams where there were child protection concerns. We also examined a sample of case commencements in order to find out whether sufficient checks had been made to establish whether staff knew about the existence of children linked to an offender and if these children were known to children's social care services.

75. We were supported in this inspection by inspectors from Ofsted and Her Majesty's Inspectorate of Constabulary.

Probation trusts: key themes

Identification

76. Processes were in place to identify children and young people who were known to children's social care services and connected to an offender in some way, although these systems were not always sufficiently robust. For example, Probation Trusts tended to record cases by the name of the offender with whom they were in contact, but children's social care services recorded the child's name.

Referrals

77. Systems for the collation, monitoring and quality control of referrals to children's social care services where there was a child protection concern were underdeveloped and there was little managerial oversight.

Assessment and planning

78. Whilst practice varied and there were some offender managers who were good, there appeared to be a lack of an 'investigative approach' on the part of some staff and a feeling that the responsibility for child protection lay with children's social care services. Child Protection Plans were not always in the case file and actions arising from them were often not mentioned in Probation Risk Management Plans.

Interventions

79. For the most part, work was characterised by insufficient liaison with social care, lack of engagement and attendance at meetings coupled with a lack of management oversight.

Management and governance

80. Clear child protection policy and procedures were generally in place but not always followed.

81. Probation Trusts did not always see child protection work as a strategic priority and an effective contribution to the local safeguarding children board was not always evident.

82. Performance management data did not help managers to oversee child protection work who often relied on probation staff to bring it to their attention.

Youth offending teams: key themes

Identification

83. Processes were in place to check with children's social care services to establish whether there were child protection concerns about children and young people known to the the youth offending team (YOT). This information was recorded on case management systems.

Referrals

84. Referrals to children's social care services were appropriate and included the right information. Responses were not always monitored properly and in some cases there was a too ready an acceptance of the decision of children's social care services not to take action.

Assessment

85. The assessments made by YOTs on children subject to child protection plans did not always include a full social care history and they did not utilise police information. It was rare to find a case checked with probation to gain information about adults.

86. Vulnerability assessments failed to draw all the threads together and lacked analysis.

87. Child sexual exploitation was a significant issue, but this was not always dealt with well in assessments.

Planning

88. Plans were too descriptive, not task focused and not always aligned with child protection plans.

89. The involvement of other agencies was not always clear, parents and carers were absent from plans and they were not often shared with other agencies

90. Where we saw the 'Signs of Safety' framework used, it seemed to have improved the planning.

Interventions

91. We saw some good work by YOT workers. They are often the most involved workers. Home visits were often used effectively to monitor the child/young person.

92. Invitations to child protection meetings were not always evident and where they were, not always timely. Minutes from meetings were not always sent or prompt and reports by YOT staff to the meetings did not always focus on child protection issues.

93. Generally we found good attendance and contribution to child protection meetings on the part of YOT staff.

Management and governance

94. YOT managers had the management data to allow them to audit and maintain an oversight of child protection work.

95. YOT work not always fully understood or utilised by children's social care services. However in most areas information sharing was good and prompt.

Chapter 5: Her Majesty's Inspectorate of Prisons

96. This content describes findings in relation to child protection and looked after children from four inspection reports published by Her Majesty's Inspectorate of Prisons (HMI Prisons) between July 2013 and February 2014. The Youth Offending Institutes concerned are Feltham (juvenile site), Warren Hill, Cookham Wood and the Keppel unit at Wetherby.

Summary

97. A common theme running through each inspection was the positive impact made by the seconded social workers, particularly in the support of looked after children. At most of the establishments, governors were closely involved in the oversight of child protection referrals. Procedures and relationships with the local authority in which the establishments were located, generally worked reasonably well.

98. The main issue establishments had in relation to looked after children was trying to ensure that the home local authority, always met their obligations. Despite some good efforts by staff working in the settings, reviews did not take place consistently and financial support was not always provided. There were often difficulties helping looked after children obtain suitable accommodation on release.

Child protection

99. At Keppel, we reported that improved procedures were now in place and at Cookham Wood, the quality and timeliness of referrals had got better. We also found that communication with the local authority had improved. It was significant that since the previous inspections, seconded social workers had taken up post and become involved in developing child protection work at both these establishments.

100. At Feltham, all complaints about staff or incidents of use of force were referred to the local authority and police child abuse investigation team. Responses were prompt and some young people had been interviewed by a police officer following the initial referral. Similarly at Warren Hill, all complaints about staff or use of force were referred to the local authority, whose responses were timely. One referral had been subject to police investigation.

101. At Cookham Wood, complaints about staff were also referred out.This was principally to Medway, but a few to other local authorities if the young person had disclosed historical abuse or concern for siblings, or had complained about treatment in other places of custody. At Cookham Wood, young people who had made a complaint about a member of staff were interviewed by a representative of the local authority with responsibility for allegations against staff, who also reviewed relevant documentation and CCTV footage.

102. At Keppel, the local authority designated officer (LADO) played an active role in child protection work and was consulted about and gave advice on all child protection referrals. An average of between two and four referrals were generated each month from the unit, about half of which concerned historical abuse and most of the remainder were complaints from young people about the use of force.

103. At Keppel, Warren Hill and Feltham, the governor in charge reviewed child protection referrals on a regular basis and signed off completed referrals. At Warren Hill this involved a monthly meeting which the local authority and police attended. As an additional safeguard at Warren Hill, the LSCB was invited to review and sign off completed referrals. At Feltham, as well as the internal procedures, records were subject to additional scrutiny by the deputy director of custody for London and the LADO.

104. Strategy meetings were not common, for example there had been none at Feltham in 2012. The majority of referrals made by the prisons were returned to the establishment to deal with. We saw evidence of internal investigations being conducted at Feltham, Warren Hill and Cookham Wood. Some members of staff had been suspended following internal investigations and at two establishments, disciplinary action had been taken following investigations.

Looked after children

105. In the surveys HMI Prisons conducted as part of these inspections, the lowest number of young people at any one establishment who said they were looked after was 27%, rising to 47% at the highest. During 2012 at Feltham, according to figures produced by the establishment, 472 young people who had been looked after by their local authority were located there.

106. All four establishments had seconded social workers working on site, and they focussed on the needs of looked after children. Warren Hill was the only establishment with a complete looked after children policy, although other establishments had produced versions in draft. The way looked after children were identified within establishments varied. Staff at Warren Hill scrutinised all documentation received on admission and carried out interviews with all new arrivals. At Feltham, initial documentation was scrutinised but interviewing of new arrivals was in abeyance, because of a vacancy in the social work team. At Cookham Wood and Keppel all initial documentation was scrutinised.

107. All the establishments inspected wrote to local authorities, reminding them of their obligations to looked after children in custody. We found that the financial support subsequently provided was inconsistent. At Feltham, social workers indicated that the minimum standard of financial support should be £10 and in most cases they had been successful in obtaining this. Warren Hill and Cookham Wood proposed that the local authority provide financial support of between £5 and £10 a week. Appropriate support had been secured in some cases, but a number of children who had been on a voluntary care order were not receiving any financial support from their home local authority at these two establishments. At Keppel, appropriate financial support had been secured in some cases, but a significant number of young people did not receive adequate financial support from their home local authority.

108. Efforts were made at all four establishments to ensure that the circumstances of looked after children were reviewed by their local authority while in custody. At Keppel, we were advised that there had been a steady improvement in the number of reviews taking place since October 2012, although some local authorities did not meet their obligations. At Cookham Wood, we were advised that in the four months from October 2012 to January 2013, 25 looked-after reviews had taken place, although because information was not complete, it was not clear how many there should have been. At Warren Hill, success in securing a review sometimes depended on whether the local authority independent reviewing officer knew the young person. The picture at Feltham was similar where looked after children reviews did not always take place.

109. Obtaining suitable post-release accommodation for looked after children was a common difficulty. At Keppel and Cookham Wood in particular there were concerted efforts by internal caseworkers and social workers to ensure that local authorities fulfilled their responsibilities to accommodate young people. At Keppel we found that confirmation of move on accommodation was sometimes received very late. At Cookham Wood we found that if caseworkers were unable to secure accommodation in good time, the independent advocate escalated matters to try and reach a resolution.

Conclusion

110. The inspection programmes described in this report will continue alongside the integrated and targeted inspection programme once it begins in April 2015. During this time, we will continue to reflect on the learning from these inspections as new models for 2016 and beyond are developed. Our shared stakeholder advisory forum will continue to meet and we will engage closely in dialogue about our future plans.