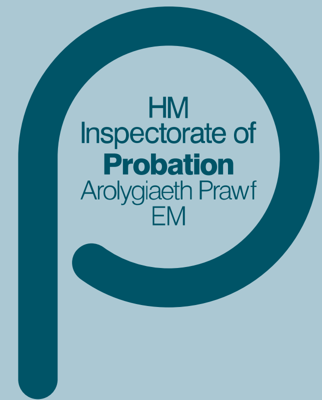

An Inspection to Assess the Effectiveness of the Reporting, Monitoring and Learning from the Youth Justice Board's Community Safeguarding and Public Protection Incident Procedures

June 2015

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An Inspection by HM Inspectorate of Probation

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Foreword

Working with children in Youth Offending Teams presents challenges to frontline workers and managers, and the complexity and demands of many cases are often underestimated. Good practice can be taken for granted and frequently goes unnoticed. However, when things go wrong it is the responsibility of leaders to ensure that lessons are learned. In this report, we examine how well the system set up by the Youth Justice Board works in ensuring that these lessons are learned when a serious incident, relating to safeguarding or public protection, has occurred involving a child known to a Youth Offending Team.

We found that while there were good intentions, the procedures in place had not facilitated a sufficient level of local and national learning. More work was required to achieve meaningful learning in order to minimise the risk of further serious incidents taking place. Not identifying the right learning meant not identifying the right actions and this was not picked up by good quality assurance of the processes. It was a matter of significant concern that the management information system used by the Youth Justice Board to monitor the processes does not work as it should and this resulted in high levels of frustration and wasted time.

Although in many cases, actions arising from reviews of serious incidents were too focused on day-to-day operational concerns and did not drive systemic change, we did see some examples of promising practice. This included sensitive debriefing of staff and the use of external reviewers to help ensure that reviews were impartial. However, this work was not supported by the dissemination of aggregate findings from the centre.

Perhaps the major area for improvement lies in widening the scope of the reviews. Increasingly, the review is a single agency (Youth Offending Team) review of a multi-agency case and so fails to deliver the required changes for all agencies. This is particularly true of Looked After Children.

We do acknowledge that the procedures that are in place reflect the fact that the Youth Justice Board is not responsible for the day-to-day operational management of Youth Offending Teams. The Youth Justice Board has moved from a position of quality assuring reviews and, overall, this had not been picked up by local partnership arrangements as had been intended and this was a significant gap. While relatively rare, serious incidents connected to safeguarding and public protection can have catastrophic consequences for all concerned. It is, therefore, of the utmost importance that proper learning takes place in order to reduce the likelihood of similar events happening in the future. The recommendations in this report are intended to help achieve this.

Paul Wilson CBE
HM Chief Inspector of Probation

June 2015

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Summary of findings

The Youth Justice Board Community Safeguarding and Public Protection Incidents procedures[1] govern how, and when, Youth Offending Teams (YOTs)[2] report safeguarding and public protection incidents and the support that they can expect to receive in so doing. Increasingly, YOTs work with a small cohort of complex and highly vulnerable children[3]; when things go wrong and the child or wider public are harmed it is crucial that lessons are learned from what has happened in order to reduce the likelihood of it happening again. Failure to do so could lead to further serious incidents and considerable reputational damage to the organisations involved. It is right that the Youth Justice Board provides leadership in this important area of practice.

The purpose of the inspection was to assess the effectiveness of the reporting, monitoring and learning from the Community Safeguarding and Public Protection Incidents procedures. We visited 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 4 month period in 2014. We also interviewed key Youth Justice Board and YOT managers.

Overall, the YOTs in our sample were able to identify qualifying cases and refer appropriately to the Youth Justice Board. The majority had put a lot of effort into this work and we saw some promising practice. However, more work is required to achieve meaningful learning. Too often, learning reviews had failed to incorporate aspects of the child's behaviour and life experiences which could have helped to explain why the serious incident had occurred. Furthermore, learning reviews did not always identify the right lessons to be learnt, which could then be translated into appropriate action to improve practice. Local oversight and quality assurance arrangements had often not been robust enough to address this. The Youth Justice Board had decided, in developing the system, not to include a mechanism to assure itself of the quality of the learning review and report submitted to them.

The Community Safeguarding and Public Protection Incidents procedures require that the Critical Learning Report is focused on immediate YOT led learning. While this model has its merits, a large proportion of the cases in our sample were known to more than one agency. This was not surprising given the profile of the children involved. While YOTs would often identify learning relevant to other agencies they did not feel empowered to draft actions which applied to the work or procedures of other services. This was a direct consequence of conducting a single agency review on a multi-agency case and was particularly marked for Looked After Children[4]. A more appropriate wide ranging learning review was rarely undertaken and meant that significant issues linked to the serious incident were not always addressed.

The Youth Justice Board management information system set up to capture and monitor serious incidents does not work as it should and results in a high level of frustration and wasted time for all involved. The Critical Learning Report is a significant piece of work for YOTs and they rightly expect to receive an annual report on national trends, good practice and learning. This had not happened since the launch of the Community Safeguarding and Public Protection Incident procedures in April 2013, although there had been some other methods employed to share learning with YOTs.

1 Youth Justice Board for England and Wales (2013) *Community Safeguarding and Public Protection Incidents (CSPPI) - Notification and Learning. Standard operating procedures for youth offending teams.*
2 Unless referring to a specific service by name, the generic term YOT is used since this is the term found in the legislation. However, local areas operate a variety of models and terms to deliver work with children and young people who have offended.
3 HMI Probation uses the term child/children to refer to children and young people under the age of 18 years old. Where the text is taken directly from the YJB CSPPI guidance the term 'young person' is used.
4 Looked After Child/Children - term used to identify a child or young person whose care and welfare is undertaken by the local authority.

Recommendations

The Youth Justice Board should:

1. in light of this report, and in consultation with YOTs, review its Community Safeguarding Public Protection Incidents procedures, specifically to include the following:
   a. guidance to YOTs on how best to learn from serious incidents when more than one agency is involved and how to embed learning locally. This should include an exemplar Critical Learning Report **(see chapter 3 Learning)**
   b. clearer guidance to YOTs leading Critical Learning Reviews concerning Looked After Children, including the need to involve children's social care services in the review, a more flexible reporting timeline and the merits of an Extended Learning Review **(see chapter 3 Looked After Children)**
   c. guidance to YOT Management Boards and Local Safeguarding Children Boards about how to support and challenge YOTs through this process **(see chapter 4 Local Learning)**
2. conduct periodic sampling of the quality of Critical Learning Reports, including reviewing the case record and interviewing staff and managers. Thereafter to provide written feedback **(see chapter 4 National Learning)**
3. ensure that the information system used to capture serious incidents and monitor reports and action plans is able to do so effectively **(see chapter 3 Identification and Notification)**
4. publish a report drawing together key trends, lessons learned and promising practice identified since the launch of the Community Safeguarding Public Protection Incidents procedure **(see chapter 4 National Learning)**.

The Chairs of Youth Offending Team Management Boards should:

5. ensure that partner agencies contribute to Critical Learning Reviews on the children that they are providing a service to **(see chapter 3 Learning, Looked After Children)**
6. hold all relevant agencies to account for the completion of actions made within Critical Learning Reports **(see chapter 3 Actions)**
7. ensure that there is independent scrutiny of Critical Learning Reports and where necessary nominate a Management Board member to undertake this role **(see chapter 4 Local Learning)**.

Youth Offending Team managers should:

8. refer all serious incidents to the YOT Management Board and Local Safeguarding Children Board, along with an annual report outlining lessons learned and progress against agreed actions **(see chapter 4 Local Learning)**
9. where indicated by the case, invite partner agencies to participate in Critical Learning Reviews and include learning and actions for them within Critical Learning Reports **(see chapter 3 Learning)**
10. allocate Critical Learning Reports to managers with a degree of independence from the case being reviewed and support them to identify both operational and strategic actions **(see chapter 3 Quality Assurance, Actions)**
11. ensure that all Critical Learning Reports are thoroughly quality assured, by a senior manager of sufficient independence who has also reviewed the case record, before submission to the Youth Justice Board **(see chapter 3 Quality Assurance)**
12. make more use of the Extended Learning Review in cases where more than one agency is involved and in particular for serious incidents involving Looked After Children **(see chapter 3 Learning, Looked After Children)**.

Community Safeguarding and Public Protection procedures: a summary

1

1. Community Safeguarding and Public Protection procedures: a summary

1.1. Under the Youth Justice Board (YJB) Community Safeguarding and Public Protection Incidents procedure (CSPPI), launched in April 2013, YOTs are required to notify the YJB and comply with specific reporting requirements[5] for two categories of 'serious incident'. These incidents can be described as significant events either linked to safeguarding children (the child has been significantly harmed) or incidents relating to public protection (the child has been charged with a particular offence causing serious harm to the public). Notifications should take place where the YOT has, or has recently had, statutory responsibility for the child, for example through a court order or through work on a police caution. The CSPPI procedure makes provision for both mandatory and discretionary reporting as shown below:

Mandatory reporting

Safeguarding the Young Person Where the following has occurred:	Public Protection Young person is charged with:
Death of a young person	Murder/Manslaughter
Attempted suicide	Rape
Victim of rape (formal allegation made to the police)	A MAPPA* serious further offence when the young person is already subject to MAPPA

* Multi-Agency Public Protection Arrangements (MAPPA) - probation, police, prison and other agencies working together locally to manage offenders who are of a higher risk of harm to others.

Discretionary reporting

Safeguarding the Young Person Where the following has occurred:	Public Protection Young person is charged with:
Victim of sexual abuse/exploitation	An offence which falls within the MAPPA serious offence category
Victim of serious physical/emotional abuse	
Serious self-harm	

1.2. Children who are on prevention programmes delivered by the YOT are not under statutory supervision, but if the YOT feels that their own involvement was such that there may be learning to be gained, the option of a discretionary notification is available. A separate reporting system is in place for incidents that occur within the secure estate and does not form part of this inspection.

How to notify the YJB

1.3. Notification and reporting of serious incidents is undertaken electronically through the secure Youth Justice Management Information System (YJMIS). YOTs receive an acknowledgement email and contact name within their local YJB business area/YJB Cymru (the YJB division within Wales) with whom they can discuss the case.

5 Grants Administration Unit YJB (2014) *Youth Justice Good Practice Grant: Terms and Conditions of Youth Justice Good Practice Grant 2014-15.*

Critical Learning Reviews

1.4. When a notification is made to the YJB the YOT is required to complete a Critical Learning Review and to submit a Critical Learning Report within ten working days of the notification. The YJB provide a report template to do this. The purpose is to capture immediate YOT led learning from an incident, both issues of concern and any identified good practice. It is expected that the Critical Learning Review will be brief and act as a prompt for further discussion and analysis as well as recording any urgent action which needs to be taken. It is not intended to be used in place of an Extended Learning Review, or any other more detailed review which seeks to understand the systemic issues which may have contributed to problems in the case.

Role of the YJB

1.5. Each incident that is reported will be assigned to an individual YJB staff member located in the relevant YJB business area in England or YJB Cymru. Their role will be to provide advice where necessary, and to work with YOTs to consider the appropriate steps for reviewing and learning from what has happened. The YJB are also responsible for drawing upon nationally identified learning and disseminating any effective practice. The YJB do not provide quality assurance of the Critical Learning Report and do not review the case. This is a departure from the predecessor process for 'Serious Incidents in the Community'[6] operating from 2005-2013 which involved the YJB in quality assuring the YOT report.

1.6. The new process was partly driven by feedback from YOTs about the relative inflexibility of the previous system, and its lack of interaction with local arrangements. The UK Government's drive to reduce centralised monitoring and reporting requirements was also a factor. The aim being to entrust local areas to manage their own performance and quality assure their own work. It was envisaged that the new CSPPI procedures would provide more consistent reporting, secure data collection and improved local, regional and national learning. The implementation of the new procedures was supported by briefing events in all YJB business areas in England and YJB Cymru.

6 Youth Justice Board for England and Wales (2005) *Serious Incidents - Policy and Guidance on Reviewing Serious Incidents*.

Purpose of inspection, scope and methodology

2

2. Purpose of inspection, scope and methodology

2.1. The purpose of our inspection was to get an early assessment of the effectiveness of the YJB procedures in place to help YOTs to learn from cases where things have 'gone wrong'. Our intention to inspect this aspect of practice in YOTs mirrored the long-standing arrangements that HMI Probation had with the National Offender Management Service; whereby our inspector with lead responsibility for public safety provided a quality assurance role as part of that agency's internal review of cases where an adult offender under probation supervision had gone on to commit a Serious Further Offence[7].

2.2. Our inspection was conducted in three stages:

Stage one: desktop review

During the first stage inspectors conducted a desktop review of the quality of a sample of 30 serious incident notifications and accompanying Critical Learning Reports supplied by the YJB. This was done without the benefit of looking at the YOT case records or interviewing the YOT manager concerned. Inspectors did not find it easy to judge the quality of the Critical Learning Report without access to the case records. However, in line with the drive to encourage quality assurance at a local level, these are the circumstances in which YJB staff receive and sign off Critical Learning Reports.

Stage two: full review

The second stage involved visiting the relevant YOT to examine their case records to see if they supported the content of the Critical Learning Report. We then held a joint meeting with the YOT Manager and Chair of the YOT Management Board. Lines of enquiry included:

- whether the right learning was identified
- did the actions in place flow from the identified learning?
- progress made against the actions agreed
- the arrangements in place to quality assure the Critical Learning Report
- how findings are shared and what lessons have been learned
- local arrangements for reporting and learning from serious incidents.

We then interviewed the YJB heads of business areas/YJB Cymru holding oversight for performance and improvement of the YOTs visited, to look at how they advise and support YOTs through this process.

Stage three: the national picture

Following our visits to YOTs and meetings with YJB heads of business areas/YJB Cymru a meeting was held with YJB senior managers with responsibility for the CSPPI process. The purpose of the meeting was to consider how the YJB monitors the effectiveness of the procedures and shares the findings and learning from CSPPI nationally.

7 Serious Further Offence - when an offender is charged with an offence classified as a serious sexual or violent offence, probation services conduct an investigation and review of the management of the case.

Inspection sample

2.3. Thirty Critical Learning Reports submitted to the YJB on serious incidents that occurred between 01 January 2014 and 30 April 2014 were selected from a long list of fifty nine cases. Two-thirds of our selected sample related to safeguarding incidents and one-third public protection incidents, a similar proportion to the 2013-2014 YJB annual return. Within our sample, notifications had been made under the following categories:

- Safeguarding (mandatory): 16 cases, of which 14 were attempted suicide and 2 relating to the death of a young person
- Safeguarding (discretionary): 4 cases including self-harm/reckless behaviour, risk of child sexual exploitation and victim of wounding
- Public Protection (mandatory): 9 cases, of which 3 had been charged with murder/manslaughter, 4 charged with rape, 1 sexual activity with a 15 year old and 1 possession of imitation firearm and assault (the last 2 qualified for mandatory reporting by virtue of committing the offences while subject to MAPPA)
- Public Protection (discretionary): 1 case charged with a firearms offence.

2.4. Two cases in the sample were managed at Level 1 (the lowest of three levels) within MAPPA locally. A further case met the criteria for MAPPA but had not been identified as such before the serious incident happened. None of the cases qualified for a mandatory MAPPA Serious Case Review.

2.5. Only one case in our sample also had a completed Extended Learning Review. Because of the low incidence of Extended Learning Reviews within our sample and also more generally (seven within the 2013-2014 reporting period) we limited our inspection to the effectiveness of Critical Learning Reports.

Case characteristics

2.6. The individuals in our case sample had the following characteristics:

- 22 were male
- 8 were female
- 20 were white British
- 14 were Looked After Children (of which 5 were placed away from their home area)
- 3 were subject to a pre-court disposal
- 24 were sentenced to a community disposal
- 3 had received custodial sentences.

2.7. A short pilot inspection took place in Kent followed by inspections at a selection of YOTs drawn from five YJB business areas in England as well as YJB Cymru. A total of 19 YOTs were visited. These were Birmingham, Buckinghamshire, Cardiff, Darlington, Doncaster, Ealing, East Sussex, Essex, Hackney, Hampshire, Manchester, Neath Port Talbot (now part of Western Bay), Sefton, South Tees, South Tyneside, Staffordshire, Surrey, Wandsworth and Wigan.

Our findings

3

3. Our findings

Identification and notification

3.1. In 2013-2014, 95 out of a total of 158 YOTs (60%) had reported at least one serious incident. There are no reliable means for the YJB to know whether YOTs are identifying and notifying all qualifying incidents. The YJB had recently, as part of an internal review, cross-referenced a snapshot of mandatory public protection incidents with their own separate record of qualifying offences and found very few missed cases. It was not, however, possible to undertake a similar exercise for discretionary notifications or for any safeguarding incidents, which account for the great majority of notifications.

3.2. Apart from monitoring media reports, YJB heads of business areas rely on YOTs to identify serious incidents and are available to provide advice when YOTs are unsure. While some YOTs found the advice to be risk averse i.e. a default position of reporting, others valued the discussions and advice imparted.

3.3. As illustrated by the table below, the great majority of notifications within our inspection qualified under the YJB guidance. There were some exceptions, for example submission before being charged with a qualifying offence and the use of discretionary reporting for attempted suicide, when it was questionable whether the attempt was genuine.

Does the incident qualify under the YJB CSPPI notification procedure?	
Yes	26 (87%)
No	4 (13%)

3.4. We saw good use of discretionary reporting to promote learning, for example in the case of a child who was the victim of a stabbing. By completing a discretionary Critical Learning Report, Ealing YOT had been able to consider the protection and support of family members as well as the child involved. This then led to a partnership review of the case to draw out further learning.

3.5. YOT managers were able to describe a range of methods used to help them identify qualifying incidents. This included raising awareness among court staff, regular discussion at team and management meetings, as well as receiving early warning from local police and checks with the YJB. Some YOTs were also drawing upon health workers and psychologists to confirm cases of attempted suicide and this was helpful. Buckinghamshire Youth Offending Service (YOS) had developed a 'serious incidents flowchart' to provide an at a glance guide from identification through to report completion and sharing lessons learnt which served as a valuable reminder to staff.

3.6. Upon notification, YOTs are required to confirm some basic initial details including the date and time of notification and nature of the child's contact with the YOT. As shown in the table below, almost one-quarter of notifications contained insufficient basic details, particularly around confirmation of notification to key stakeholders; for example the YJB, YOT Management Board, Local Safeguarding Children Board (LSCB)[8] and also on occasion the wrong offence category, type of order and ethnicity.

Does the notification page include sufficient initial details?	
Yes	23 (77%)
No	7 (23%)

8 Local Safeguarding Children Board - set up in each local authority to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children.

3.7. As noted below, few Critical Learning Reports were completed within the specified ten working days from notification. We found that only ten had been submitted 'on time'. The ten day timeline was designed to produce a swift review to pick up on immediate learning for the YOT. We found nine that were over three weeks late, of which three were over two months late. It was confirmed to us that one was only completed because of the inspection.

Was the Critical Learning Report completed within 10 working days of submitting the notification?	
Yes	10 (33%)
No	20 (67%)

3.8. The ten day timeframe posed problems in some cases, particularly where there were a number of agencies involved with the child and a traumatic incident had occurred, for example when someone had died. In one such 'late' submission the case file confirmed that appropriate information gathering meetings were taking place during the ten day period, in line with local expectations. One YOT manager stated: "*Ten days is insufficient to pull together a multi-agency perspective, and that doesn't fit within our learning culture*". Another noted: "*We don't mind reporting but we would like it to fit more flexibly into our own systems*". However, within our sample we found that taking more time to complete the Critical Learning Report did not necessarily result in better quality learning or effective setting of actions.

3.9. Both the YJB and YOTs relied on YJMIS to capture the notification and Critical Learning Report. Almost universally, YOTs told us that they encountered difficulties in the use of YJMIS and that it had impacted on their ability to report fully and/or within YJB timeframes. Specific issues at the time of our inspection included:

- the system 'timing out' and resulting in loss of data or being unable to upload a Critical Learning Report
- Critical Learning Report action plans do not always pull through and require a separate submission. This was seen in our sample when we were provided with some reports without an action plan, later to receive one at the YOT
- YJMIS records actual days as opposed to working days and therefore provides an inaccurate reflection of the timeliness of reporting.

3.10. YJB heads of business areas/YJB Cymru also reported difficulties with this system, hampering their ability to track notifications and record comments; we were told: "*We don't have a central reporting tool that gives us anything worth having*". Similarly, inspection case sample selection was impeded by recording issues, including multiple entries against one incident and Critical Learning Reports showing as missing when, in fact, they had been completed.

3.11. The issues described resulted in high levels of frustration amongst YOTs and considerable time being wasted. Effort was spent trying to work around the system with YOTs tending to complete the Critical Learning Report in a 'Word' document and pasting that on to the system as opposed to inputting directly, as was intended. These frustrations were sometimes recorded within the report itself which, although understandable, should be focused on the learning from the case. In one area an inspector noted: "*The frustrations with the CSPPI/YJMIS system are reflected in the fact that three of the eight actions have to do with 'fixing' the system*".

3.12. In response, the YJB has made a number of requests to the providers of YJMIS asking for changes to the system, dating back to August 2013. However, further changes are on hold as the system as a whole is being reviewed. The considerable issues with YJMIS mean that a detailed manual data cleanse would be required before Critical Learning Review findings could be analysed and used to inform policy and practice.

Quality of Critical Learning Reports

3.13. The YJB provide a template to complete the Critical Learning Report subdivided into the following sections:

Report Section	Purpose
Young person's behaviour	To reflect on any factors in the young person's life that could have helped to predict that the incident might occur. Where a risk of harm had previously been identified to consider what was in place to manage the risk and protect the young person and/or the public.
Learning	To identify critical learning that needs an immediate response or which would benefit from being shared. It is not about finding fault in the practitioner which should be considered separately.
Good/effective practice	An opportunity to acknowledge and share any good or effective practice identified in the case.
Quality assurance	It is expected that the critical learning review is subject to a level of independent scrutiny for example from the YOT Management Board, LSCB, MAPPA panel or through peer review.
Actions	It is expected that the findings of the review turn into actions which are monitored.

Young Person's behaviour

3.14. The table below shows inspectors' view of the quality of the child's behaviour section of the Critical Learning Report both before (desktop review) and after our assessment of the case file (full review). Upon desktop review almost two-thirds were considered to be at least sufficient. The best examples were those that provided a concise summary of factors in the child's life that could help to predict that the incident might occur, for example their experience of abuse, self-harm and use of drugs and alcohol.

Young person's behaviour	Desktop review	Full review
Good	5 (17%)	5 (17%)
Sufficient	14 (47%)	5 (17%)
Insufficient	9 (30%)	13 (43%)
Poor	2 (7%)	7 (23%)

3.15. Having thought that almost two-thirds were sufficient or good upon desktop review this dropped to one-third when inspectors reflected on the information contained within the case record. We found that a number of relevant aspects of the child's experiences had been omitted, including their experience in care, being a victim of child sexual exploitation, the child's vulnerability, or disturbing aspects of their current or past behaviour; for example towards victims. All of which needed to be drawn into this section, to give a full picture of the child's life and what may have predisposed them to such behaviour. This was particularly true for children looked after by the local authority.

3.16. Rather than providing an analysis of the impact of the child's circumstances, too often this section contained a statement about what had happened accompanied by the child's record of offending.

Comments from Inspectors

"*After reading the case file it became evident that the Critical Learning Report did not provide a good enough picture of how the child's history and behaviour placed her at risk of harm i.e. why she had been on the Child Protection register, the nature of the sexual exploitation that she had been subject to and remained at risk of*".

"*This is a very damaged young woman who seems bent on self-destruction. They are working very hard to engage her. There is a lot of information on file but little real analysis of her behaviour, what it means and her needs. The report does not gather her behaviour together and analyse it*".

Learning

3.17. One of the stated benefits of the CSPPI procedure is: 'meaningful learning from incidents when they occur'. Indeed, this should be seen as the most important aspect of the exercise. As shown in the table below, upon desktop review of the learning section of the report over two-thirds were felt to be at least sufficient. The best examples were those where report authors had been able to critically reflect upon the quality of work undertaken in the case. In so doing they were more likely to identify matters that needed swift action, for example poor case transfer, inadequate communication with other agencies and shortcomings in the quality of mental health assessment.

Learning identified	Desktop review	Full review
Good	6 (20%)	6 (20%)
Sufficient	15 (50%)	4 (13%)
Insufficient	6 (20%)	15 (50%)
Poor	3 (10%)	5 (17%)

3.18. As with the previous section, with the benefit of reviewing the case records and meeting with managers, inspectors found that only one-third of Critical Learning Reports had comprehensively identified learning from the incident.

3.19. Some reports resembled a case audit rather than a reflective approach to learning, for example citing late or incomplete assessments but missing relevant changes in behaviour prior to the incident. We saw cases that had missed apparent learning, and others that had identified learning but with no resulting action to remedy the issue. In others, an overly long and somewhat convoluted description of events meant that the key learning points were lost. This is concerning as without the right learning being identified there is less opportunity to take appropriate action to reduce the likelihood of such an incident occurring again in the future.

3.20. A number of reports identified deficits in individual practitioner work, when the more pertinent learning applied to management oversight or wider service planning and provision.

3.21. There can be value in a short, sharp review to capture what the YOT needs to change with regard to its own processes in advance of a more wide ranging local review or Extended Learning Review. However, it was rare to see the CSPPI process used effectively in this way.

3.22. Many Critical Learning Reviews were constrained by being a single agency review of a multi-agency case. In one example a child known to mental health services had attempted suicide within a social

care placement, but neither children's social care services nor mental health services were involved with the review. This same child attempted suicide again some months later and, once more, a single agency Critical Learning Review was undertaken. Such reviews of complex cases known to more than one agency were not uncommon and severely limited the potential to learn lessons. Often inspectors considered that an Extended Learning Review would have been more appropriate, as it would have involved other agencies and been more likely to identify learning and actions for more than one service.

Good practice examples

Capturing immediate learning and triggering a more in-depth review - Hackney YOT

In the case of a murder in Hackney, the Critical Learning Report had picked up on the immediate learning for the YOT: to improve intelligence sharing with the police, the gang initiative and the Multi-Agency Safeguarding Hub. Plans were put in place to conduct an Extended Learning Review to capture more in-depth and strategic learning.

Developing a learning culture - Buckinghamshire YOS

At Buckinghamshire a reflective practice model was used to debrief the case manager and to gather information for the Critical Learning Review. This focused on what had happened, why it had happened, and the consequences before considering what should happen next. This helped the case manager, in a supportive way, to identify learning from the case and agree an appropriate action plan. It was one of the few examples where the case manager was actively involved in the Critical Learning Review.

Commissioning an external consultant to undertake an Extended Learning Review - Cardiff YOT

In Cardiff, the YOT Manager had worked hard to secure an Extended Learning Review in the case of a child who had committed suicide. This was the right decision as it was clear that there would be learning for more than one agency and no other type of local review was to take place beyond the Critical Learning Review. The YOT commissioned an external consultant to undertake the Extended Learning Review and report back to the YOT Management Board and LSCB. It provided a much fuller picture of the child's behaviour than the Critical Learning Report, in particular his long-standing use of drugs and record of contact with other services such as. children's social services, education and health. It helped the YOT to pick up on important issues with Children's Social Services including arrangements for children placed on remand in Young Offender Institutions.

Good/effective practice

3.23. The identification of good/effective practice was the element of the Critical Learning Report that remained most consistent at both desktop and full review. We found that around half of the reports had identified good or effective practice within the case sufficiently well. Where this was not so, report authors had cited as good practice work that would be considered standard practice for example: 'swift enforcement', 'complied with case guidance' or 'a good intervention plan' without saying what was good about it. It is understandable that report authors would wish to note some positive element of the casework, particularly when considering the impact of some of the incidents on practitioners. However, it was sometimes difficult to elicit the good practice amongst the list of standard practice.

Good/Effective practice identified	Desktop review	Full review
Good	0	1 (5%)
Sufficient	14 (50%)	11 (52%)
Insufficient	11 (39%)	8 (38%)
Poor	3 (11%)	1 (5%)
N/A no good practice to be highlighted	2	9

Quality assurance

3.24. Another stated benefit of the procedure is 'greater reliance on local learning and quality assurance processes'. It is expected that once written, the Critical Learning Report will be reviewed by an independent person to make sure that it is of sufficient quality. The YJB CSPPI guidance suggests that this quality assurance could come from a member of the YOT Management Board, LSCB, MAPPA panel, an independent expert or through peer review (a YJB supported initiative whereby YOT managers are trained to review practice in other YOTs).

3.25. Very few of the cases in the sample were subject to quality assurance by any of the above before submission, although alternative local arrangements did exist. More often, quality assurance would constitute 'sign off' by the YOT manager, but they rarely reviewed the case themselves. There would then be an indication that the Critical Learning Report would go before the YOT Management Board or LSCB at a date to be determined. We did see evidence through Management Board and LSCB minutes of Critical Learning Reports being brought to their attention but not at a time to influence the content of the report. As one inspector noted: "*It wasn't subject to any scrutiny as far as I could tell. The quality assurance section says 'it will' go to the board, not 'it has been*". It is, however, recognised that the above suggested methods of quality assurance would be very difficult to achieve within the expected ten day turnaround for submission to the YJB.

3.26. Upon desktop review, it was rarely possible to determine the position of the Critical Learning Report author within the organisation, and the template did not prompt for this. We found that two-thirds were written by operational managers, some of whom had line management responsibility for the case. This was not considered best practice due to their involvement with key management decisions and the need for a level of detachment when things have gone wrong in a case.

3.27. However, not all YOTs had a sufficient resource to allocate to another operational manager within the service and had not developed alternative arrangements to draw upon. Allocation to the line manager was seen as a means of achieving the ten day turnaround, given their prior knowledge of the case. In these instances, the role of the quality assurer is even more important.

3.28. As shown in the table below, we found that just over one-third of cases had been subject to a sufficient level of independent scrutiny. This was often when YOTs had gone the extra mile to provide second level quality assurance of reports and/or more independent scrutiny through other managers within the service.

Was the Critical Learning Report subject to a sufficient level of independent scrutiny?	
Yes	11 (37%)
No	19 (63%)

3.29. Although we judged relatively few Critical Learning Reports as 'good' in the 'young person's behaviour ', 'learning' and 'good/effective practice' sections the vast majority of those that did achieve this had also been subject to a sufficient level of independent scrutiny.

Good practice examples

Critical Learning Report authors with a degree of independence from the service

Some YOTs were able to utilise an appropriate resource from within the wider partnership, for example in Surrey an integrated service manager, and in Essex a local authority children's services reviewing officer, this provided an appropriate level of detachment from the case.

Quality assurance at an appropriate level of independence and seniority - Wandsworth YOT

In Wandsworth quality assurance was provided by the Assistant Director with responsibility for the YOT, and he had called a meeting of relevant professionals one week after the incident. The actions that came out of the Critical Learning Review were not limited to the YOT but included work for the wider professional network. Although at an early stage of implementation, coordination at an Assistant Director level makes it possible to ensure that all services contribute to achieving the agreed actions.

Quality assurance form - Hampshire YOT

Hampshire YOT had developed a helpful form to help structure the quality assurance process. It prompted the quality assurer to ask the right questions such as: 'Is there sufficient analysis of recurring and noticeable behaviour in relation to the serious incident?', 'Does the author specifically identify what could have been done differently and how this may have impacted on the case?', 'Does the action plan incorporate specific learning points and areas for improvement highlighted in the report?'. Changes made to reports are captured on the form and provide a helpful record of quality assurance practice within the service.

Actions

3.30. Upon desktop review we could only determine if the right actions had been agreed based upon the information contained within the Critical Learning Report. As shown in the table below, we considered that 13 had identified appropriate actions that flowed from the findings of the review. A further five had gone part way to identifying the right actions.

Based on the information contained within the Critical Learning Report, were the right actions agreed?	
Yes	13 (46%)
No	10 (36%)
Partly	5 (18%)
N/A in this case	2

3.31. However, with the benefit of looking at the case records and speaking to YOT managers we identified only eight reports where the right actions had been identified. This reflected our earlier findings about the review not always identifying the right lessons to be learned, and subsequently translating this into appropriate actions. All of which was compounded by the lack of quality assurance. Consequently, the great majority of reports within our sample had insufficient actions when considering the nature of the serious incident and learning potential.

Practice example: a missed opportunity to translate learning into actions

In the case of a child who attempted suicide within his residential care home the YOT review rightly identified gaps in sharing information when the case was transferred from another area. The need for better communication with Children's Social Care Services including access to information logged in the residential unit was also noted. However, Children's Social Care Services were not involved with the review and none of these learning points translated into actions.

3.32. Critical Learning Reports tended to capture actions that were operational in nature, to the exclusion of more strategic actions, for example an action to 'review referral processes for outreach workers' when the issue was one of insufficient resources. A number covered routine YOT processes such as following National Standards for Youth Justice[9], YOT case guidance, or reviewing policies and procedures, all of which may more appropriately be captured through robust management oversight. Therefore, actions were often targeted at the practitioner level as opposed to service or partnership wide. This may reflect the fact that the majority of reports were completed by operational managers who are less familiar with the wider strategic picture and insufficiently empowered to make strategic level recommendations. Given the complex background and issues raised by a number of the cases in the sample, more strategic actions would have had greater impact.

3.33. We were pleased to see that Surrey YOS had included in their action plan an area of work identified by the report author as good practice for wider dissemination, as opposed to focusing only on deficits.

Good practice example: turning lessons learnt into actions - Wigan YOT

A Critical Learning Report completed by Wigan YOT on a troubled boy who had self-harmed for the second time in 11 days identified a lack of access to appropriate mental health assessments for children known to the service. It also highlighted a lack of understanding about the role of mental health services for children. The case prompted the YOT manager to review all YOT cases with mental health issues and to put forward two key actions. One was to secure specialist mental health advice for the YOT and another to give all YOT workers a briefing on what they could expect from mental health services. Both were achieved.

Implementation of actions

3.34. Notwithstanding our earlier finding that the right actions had not always been identified, there were only five cases where no progress at all had been made to address the agreed actions.

3.35. Generally, action plans were brought to Management Boards and sometimes to the appropriate subgroups within the LSCB, for monitoring and sign off. However, there was little evidence of in-depth scrutiny by these bodies. In some YOTs it was little more than a reporting exercise which was then left to the YOT to carry out the work with little oversight. One YOT told us that they had twice made the same recommendation of partner agency involvement without action being taken.

Overall, has sufficient progress been made on the implementation of the actions agreed following the Critical Learning Review?	
Yes	11 (48%)
No	5 (22%)
In part	7 (30%)
N/A in this case	7

9 Youth Justice Board (2013) *National Standards for Youth Justice Services April 2013*.

Good practice examples

Putting learning into practice, Hampshire YOT

Hampshire YOT has kept a detailed log of all serious incidents within their area since October 2012. Critical Learning Reports are presented to the YOT Management Board in summary form by the author. Where other agencies are involved they also go to the LSCB Serious Case Review subgroup which is chaired by the YOT Management Board Chair, thus providing continuity. 'Learning lessons' workshops are delivered periodically to all staff and provide an opportunity to share the main findings and actions arising from reports. The introduction of vulnerability screening in all Youth Courts, work with the MAPPA Strategic Management Board to provide YOT guidance for Level 1 reviews and YOT involvement in the Multi Agency Safeguarding Hub all came about as a result of Critical Learning Review findings.

Improving links with Children and Adolescent Mental Health Services - Darlington YOS

After two Critical Learning Reports highlighted insufficient links between the YOT and Children and Adolescent Mental Health Services (CAMHS), work got under way to help both agencies understand each other's business. A communication strategy was put in place, link workers identified and regular attendance secured at the YOT Management Board.

A coordinated approach to reporting actions - Staffordshire YOS

In Staffordshire the YOS Manager had initial oversight of all the action plans emanating from Critical Learning Reports and other learning reviews and ensured that there was tangible evidence of progress against each action before reporting to the Management Board. The information was collated and there had been two workshops for staff highlighting and exploring the learning from previous reviews.

Looked After Children: a special concern

3.36. The YJB data indicates that Looked After Children are over-represented in the total number of serious incidents notified by YOTs. Our sample included 14 children in local authority care of which 5 were placed outside of their home area, adding another layer of complexity. In common with the national trend the vast majority of notifications concerning Looked After Children in our sample were safeguarding incidents. Three cases related to public protection.

3.37. Although the numbers are small, we judged the quality of the information about the child's behaviour, learning from what had happened and actions taken, to be weaker for the Looked After Children sample. We judged that only 6 of the 14 Critical Learning Reports had received sufficient independent scrutiny but this was marginally better than for non Looked After Children.

3.38. One of the difficulties with the Critical Learning Review as a vehicle to identify learning and make recommendations in these cases is that they are, by definition, managed by more than one service. The shorter timeframe and single agency perspective of the Critical Learning Review process invariably meant that children's social care was not involved, and it was often that agency that had a more significant role in the case. This meant that the work of the YOT was potentially peripheral to what was actually the problem, for example, where a child was looked after out of area and moved numerous times.

3.39. Very few of the Critical Learning Reports concerning Looked After Children would also be subject to review by the local authority. In one such example the YOT had to submit another separate report to the local authority review, having already completed a Critical Learning Report. The Critical Learning Report is a substantial piece of work to undertake in these instances and the wrong vehicle to attempt to prompt another agency to conduct a local review. As one YOT manager commented: "*The process is resource intensive so we want to do reviews under the right circumstances to get the right learning. It's a matter of proportionality*."

3.40. Of the 14 cases in the Looked After Children sample only 2 contained specific actions for other agencies within their plan, despite there being relevant learning for others, for example around keeping children safe and offering appropriate services to meet their needs. In an attempt to address actions towards other agencies some YOTs used terminology such as 'to speak with children's social care….', 'children's social care may wish to…' but this was not enough.

3.41. An Extended Learning Review, or other type of local review was rarely considered for the children within our sample, but this would have been a more appropriate vehicle for learning, particularly for Looked After Children.

Practice example: lack of accountability for agreed actions when Looked After Children are placed away from their home area.

The case of a Looked After Child placed outside their home local authority illustrated the shortfalls of this process for children in this position. The Critical Learning Review was relevant to three YOTs, the home area (YOT A), initial out of area placement (YOT B) and subsequent out of area placement (YOT C) where the serious incident occurred (attempted suicide). YOT C had only been made aware that the child was in their area a short time before the incident occurred, but in line with the YJB guidance took responsibility for writing the Critical Learning Report. The report rightly contained actions for all three YOTs. However, neither the YJB nor the YOT responsible for the Critical Learning Report checked if the actions had subsequently been completed by all three YOTs.

Overall assessment

3.42. With the benefit of reviewing the case records and speaking with YOT managers, overall, inspectors revised down their judgement of the quality of Critical Learning Reports. Upon full review, less than half of the Critical Learning Reports were found to adequately reflect the information contained within the case record (see table below). This was particularly true of the sections relating to the young person's behaviour, learning and actions. Local quality assurance arrangements had not been adequate enough to address this.

Overall, does the information contained within the case record support the content of the Critical Learning Report?	
Yes	13 (43%)
No	17 (57%)

National and local learning

4

4. National and local learning

National learning

4.1. The YJB involvement with serious incidents is no longer about oversight or quality assurance of YOT practice, but a means of picking up on local and national information that the YJB may need to act upon. Critical Learning Reports are now kept centrally with the intention of analysing the data, identifying trends, lessons learnt and promising practice; in order to share with YOTs on an annual basis. However, an annual report had not yet been published. This was seen as a major gap by YOT managers who wanted both regional and national feedback to help them to benchmark their own work. This was particularly true when serious incidents were few and far between, leaving YOTs even more reliant on aggregate national learning to help them to improve practice locally.

4.2. YJB Heads of business areas/YJB Cymru are no longer expected to produce regional learning reports. They do however attend regional YOT managers meetings and in Wales, YOT managers Cymru, where they hear from and share information with regards to serious incidents. Similarly, regional effective practice forums are used to share messages arising from serious incidents. Emerging themes may then be forwarded to the YJB Head of Safeguarding who, in turn, reports to the YJB Executive Management Group. So far, shortfalls in mental health provision and problems in case transfer and cross-border practice have been identified.

4.3. YJB Heads of business areas/YJB Cymru also periodically attend YOT Management Boards and can help YOTs unblock obstacles such as access to services. They also monitor local issues and in one YOT noticed repeat actions to do with insufficient mental health services for children. The YJB staff member met with the YOT and this helped broker a service level agreement with CAMHS.

4.4. It was, however, recognised by YJB Heads of business areas/YJB Cymru that the system was not as effective as it could or should be. For example, we were told that: "*the change in the process means that we have lost a lot of detail locally*" or it had "*shifted to a monitoring process*". More positively it was felt that the new processes had brought safeguarding into more focus and that the discretionary notification encouraged conversations about practice.

4.5. YOTs were not always clear about what they could, or should, expect or what the purpose of YJB involvement was. They described varying levels of support from local areas from: "*YJB were excellent*" and "*second to none*" at one extreme to: "*there is no feedback at all from the YJB; no cross-area learning, and no aggregated reports*".

4.6. YJB heads of business areas/YJB Cymru told us that they did not feel confident signing off Critical Learning Reports without having seen the case. They found the quality to be variable, depending on the report author and their level of experience and understanding of the process, but felt that further scrutiny was beyond their remit. We were told, for example: "*I often don't know what I am seeing …but don't have the power to challenge*", "*I have too many unanswered questions*". We saw one example of a Critical Learning Report being returned for resubmission on the grounds of its poor quality, and while this was the right thing to do it was no longer within their remit. This was, however, welcomed by the YOT who benefited from assistance from the YJB to develop their practice. This was then followed by a Critical Learning Report training session for a cluster of YOTs in the area.

4.7. Currently there is no alignment between the process for learning when things have gone wrong in the community and the separate arrangements in place for children in custody[10]. This discrepancy was noted by both YOTs and the YJB. It is planned that this will change in the future although some degree of separate reporting will remain for children in custody.

10 Youth Justice Board (2009) *Protocol for Reporting Serious and Significant Incidents*.

4.8. YJB senior managers interviewed recognised that while the YJB had access to more meaningful information than under the old system a clear process for drawing out learning was the weakest aspect of the procedure.

Local learning

4.9. YOT Management Board Chairs were clear that overall responsibility for serious incidents rested with them and were content that YOTs were complying with the YJB procedures.

4.10. The actions contained within the Critical Learning Reports were monitored in various ways; within the YOT, within the YOT Management Board, at an LSCB subgroup, or a mixture of all three. However, as noted previously, genuine scrutiny was often lacking.

4.11. It was not always clear how the CSPPI process fitted with local strategic processes, except as a reporting mechanism. In some areas it seemed to be viewed as a possible trigger to prompt a further review, although we saw very little evidence of this. In one area, the YOT manager had had to work very hard to get Critical Learning Reviews on to the agenda of the LSCB in the face of objection from the chair.

4.12. A number of YOT managers noted that robust scrutiny from outside the service was lacking, compared to when the YJB provided this through quality assurance of their reports. With some notable exceptions, YOT management boards and LSCBs had not filled this gap.

4.13. The majority of YOTs missed the structured feedback and challenge that the YJB provided under the old system. YJB quarterly reviews of YOT performance included some reference to CSPPI, but usually this was limited to a line about the number and types of reports submitted. This was a missed opportunity to provide some regular feedback about the quality of Critical Learning Reports. One YOT had asked for explicit feedback on their reports and had received helpful correspondence from their YJB area team.

4.14. It was easier to aggregate local learning in larger authorities with a higher throughput of serious incidents. For example in Manchester, after 15 incidents of self-harm in 1 year, the YOT worked with partners to design a citywide process to assess the seriousness of episodes of self-harm. They agreed a common definition and reporting process. Without a throughput of serious incidents, learning tended to be specific to the individual case, and, unless captured as part of the national picture, wider improvements over time would be difficult to evidence.

4.15. It appeared to be even less likely that there would be a multi-agency review for a public protection notification than for safeguarding. Public protection serious incidents would rarely qualify as mandatory referrals to MAPPA and were very much seen as YOT business. While the YOT has the role of assessing and managing the risk to others that the child poses, and is therefore a key agency in any review, a number of the children will be known to other services. The actions of other agencies may have impacted on the risk posed to the public, and so a single agency review may not be the most effective method of identifying learning in these cases either.

> “*When there is professional trust and respect amongst colleagues, as with the members of the YOT board, complacency can set in. Critical Learning Reports are not exactly ‘nodded through’; however the board members are not exposed to the full details of the case or incident.”*
>
> YOT Management Board Chair.

Role of the inspectorate and code of practice

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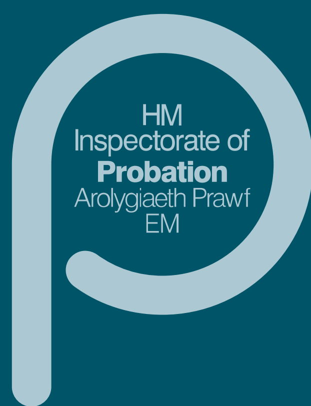

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