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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to sexual abuse in the family in York

Between 24 and 28 September 2018, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to sexual abuse in the family in York.¹ This inspection included a 'deep dive' focus on the response to sexual abuse in the family environment.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in York.

This joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door' for referrals about children who may be in need or at risk of significant harm. In York, this is known as the 'children's front door'. Co-located within the children's front door are local authority social workers from the referral and assessment service, who sit within the service for one week in every three, the police vulnerability assessment team (VAT) and the lead nurse for safeguarding from the healthy child service. The children's front door also considers whether children's needs can best be met through the provision of early-help services. Alongside this inspection of 'front door' arrangements, which had an emphasis on referrals relating to child sexual abuse in the family environment, inspectors also undertook a 'deep dive' into the effectiveness of services for a group of children and young people who have suffered, or are at risk of, sexual abuse in the family environment. Inspectors

¹ This joint inspection was conducted under section 20 of the Children Act 2004.



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also evaluated the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board (LSCB). Local agencies share a strong common commitment to providing services that are child focused. Modelled powerfully by the effective LSCB, this approach is shared across the partnership. The partnership demonstrates a commitment to shared learning and improvement that is characterised by robust but professional challenge. Increasingly good working relationships between agencies and their staff, from the frontline to a strategic level, underpin work with children in York when it is at its best.

In common with agencies across England, the local partnership in York has strengthened its awareness of, and services to tackle, child sexual exploitation. It has also ensured that it has retained a distinct focus on child sexual abuse in the family environment. Central to this ongoing emphasis has been the work done by the partnership to build on the legacy of the 'It's not OK' campaign of 2015–16. This has been particularly successful in strengthening the current strong engagement of schools in both safeguarding and early help work, including work to address child sexual abuse.

Although there are good working relationships between staff from different agencies within the children's front door and across the partnership, services at this early point of involvement are not well joined up and some lack sufficient capacity. Inspectors found no children at immediate risk of significant harm, where risk had not been recognised and action taken. However, the lack of capacity and consistently joined-up services does mean, that for a few children, there are delays in recognising the full extent of their needs or risk and in providing timely intervention. This is because decision-making is too reliant on local authority information and is not consistently informed by the early involvement of the right agencies and the information they hold about children. Health agencies, in particular, are not sufficiently involved.

Despite their best efforts, the healthy child service representatives within the children's front door have too wide a span of responsibility to have the capacity for consistent involvement. Coupled with some gaps in information-sharing protocols and mechanisms between health agencies, this creates barriers to the effective coordination and analysis of information about the health and well-being of children and their families. This is a missed opportunity for the partnership to further enhance the quality and effectiveness of the services that they provide for children.



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Key Strengths

- A strong, shared commitment to working in a child-focused way and listening to the voices of children and young people characterises the work of agencies in York. Driven by the influential LSCB, this approach is seen at both a strategic level and in work with individual children and their families. For example, in a recent child sexual abuse investigation involving a number of children, the police showed a child-centred and nuanced approach. They considered both when to interview children and how to ensure that the children were properly considered as victims and were not inappropriately criminalised. The police must record an offence when anyone shares an indecent image of a child, even if it is the child themselves who does this, and even if they have been coerced. However, in such situations, North Yorkshire police does not record the child as a suspect and takes no investigative action, which means that any future background checks do not suggest that the child was ever suspected of committing an offence. The children who were the subjects of this investigation received support that fitted well with their individual circumstances and maximised the likelihood of gathering the best evidence to further the criminal investigation.
- The child sexual abuse assessment centre (CSAAC) has used the observed experience of and feedback from children who have used this service to ensure that the service develops in a way that reflects children's feedback and provides an environment that is as welcoming as is reasonably possible. The use of 'you-said we-did' posters, even about such things as the provision of hot chocolate and electronic tablets to help children feel welcome while waiting to be seen, encourages children to share their views and further develop this work. There is a good range of helpful and well-considered guidance and information, including about services that relate to child sexual abuse in a family environment, on both the LSCB and York children's trust (YorOK) websites. Children and young people have been involved well in shaping this material and impressive 'hit' numbers on the site reflect this.
- The relationships between the various strategic boards in York are established and well understood. This means that the partnership has a strong framework to help focus resources on shared priorities such as tackling child sexual abuse. This can also be seen in the clear, succinct and outcome-focused children and young people's plan 2016–20.
- The Police and Crime Commissioner's (PCC) children and young people's strategy 2018–20 provides strong evidence that police leaders carefully consider the needs and wishes of children when designing services and making decisions, and that they ensure that action planning is well aligned with other multi-agency strategic plans.



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- The LSCB is an effective critical friend to the partnership, exercising leadership and challenge in order to improve services for children. The LSCB's child sexual abuse and exploitation and missing subgroup acts as an effective catalyst to the ongoing development of services for children. The group receives a broad range of child sexual abuse information, alongside its wider focus on child sexual exploitation and children who go missing from home or care. Consequently, the partnership has a good overview and understanding of the range of services in place to tackle child sexual abuse, from awareness raising, through prevention, assessment, therapy to services for children who exhibit sexually harmful behaviour. This overview supports the identification of gaps in services and guidance, and areas in need of further development. These areas include: the limited capacity of therapeutic services; some children having a long wait for services; and the need to strengthen services for children who exhibit sexually harmful behaviour. The ongoing impact of the 'It's not ok' campaign is that there has been a significantly enhanced uptake of some preventative services by schools, such as the 'Speak out, stay safe' assemblies and a positive increase in disclosures by children and young people.
- Multi-agency public protection arrangements (MAPPA) are strong, established and effective. Good health representation is a strength. There is also strong joint working between police and the national probation service (NPS), including in home visits. This makes an important contribution to ensuring that children and young people are protected from the highest risk offenders, including registered sex offenders (RSOs).
- When children are referred to the children's front door because of an immediate risk of significant harm, such referrals are dealt with without delay, and effective action is taken to ensure that children are safe. Professionals from across agencies generally have a good understanding of the threshold for referring children to the children's front door and of the process for doing this. For example, there is a clear understanding of referral routes and thresholds for intervention in both the youth offending team (YOT) and the NPS. Inspectors found that case managers were clear about levels of need that may require a statutory social work response, in contrast to those that may be best responded to with an early help offer. When referrals are received, decisions about next steps are almost always well matched to the presenting level of risk and identified needs. When children and young people go on to receive a social work assessment, these are timely and generally well informed by the full range of professionals working with the child and their family. This means that any risks or needs not identified at the initial referral stage can then be identified. It also supports plans that include actions that are well matched to children's individual circumstances and needs.
- Children and young people who have suffered sexual abuse in a family environment have access to a good range of services. This includes services



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commissioned by the PCC, which, while not specifically targeted at children who have experienced child sexual abuse, have helped a number of such children as part of their recovery. A respected national charity runs therapeutic courses for children and young people who have been victims of sexual abuse, including an innovative course for children who have not made a disclosure but about whom there are well-grounded concerns that they may have suffered abuse. There is also a 'Women as protectors' course for non-abusing mothers and other female carers. The CSAAC routinely signposts families to the independent sexual violence advocates service (ISVA) after attending the clinic. There is a high take up of this service.

- Effective leadership and a whole-council approach has been important in ensuring that the local authority continues to develop the effectiveness of its services. Those areas of practice relating to the referral and assessment of children who may be in need or at risk of significant harm that needed development at the time of the last Ofsted inspection in November 2016 have improved as a result of focused and consistent improvement activity. The local authority is using performance management and audit information well to improve performance in some key areas of practice, such as the timeliness and quality of assessments. Almost all assessments are completed in a timely manner; children's wishes and feelings are included, and analysis focuses on key risk and protective factors. Arrangements for when children are the subject of a referral out of office hours have been strengthened. In almost all cases, children receive a good service. There is good communication between daytime and out-of-hours services. The performance management of this service could, however, be strengthened and be better aligned to contract management.
- Work to tackle workforce pressures in the referral and assessment service, ongoing since the time of the last inspection, has been successful and is currently being extended to include other parts of the workforce. A well-considered approach, including recruitment and retention payments, regional management of agency pay-rates and manageable caseloads, means that turnover, vacancy rates and reliance on agency staff have significantly reduced. As a result, children are less likely to experience changes of social worker, and more likely to be able to form a relationship of trust with a single social worker, who visits them regularly and who knows and understands the context of the local area in which they live. The co-location within the children's front door of local authority social workers from the referral and assessment service, who sit within the service for one week in every three, also serves to reduce changes of social worker and manager and so enhance continuity for children and their families.
- Within the children's front door and wider referral and assessment service, managers have timely and regular oversight of work with children and young people. They provide appropriate decision-making guidance and track case-progression. This is effective in a large majority of children's cases. Although



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there is not always a strong enough emphasis on reflection, supervision is regular and provides clear direction to social workers. The recent appointment of a new advanced practitioner for child sexual abuse and exploitation and missing, and the relocation of this post to the children's front door, has strengthened the oversight of this work. It is too early to see the effect of the new post in the development of services, but inspectors did see an immediate, positive impact on the quality of work to tackle child sexual abuse in the family environment by the referral and assessment service.

- The York YOT has an active management board with good partner representation and a commitment to holding the service to account as well as supporting it to develop and innovate. There are performance management processes in place with key information on practice audits as well as quantitative information being provided to board. YOT staff are capable and committed. They show sound professional knowledge and have good relationship-based skills that are underpinned by a comprehensive staff development package.
- The NPS is engaged effectively with the LSCB. Concerns about the quality and consistency of the child safeguarding information available to support court-based assessments and reports, identified in a previous HMI Probation inspection in this area, were reported to the board. A comprehensive assurance audit conducted by the NPS earlier this year and submitted to the board provides a detailed overview of the work of the NPS and evidences clear progress against this area for development. Inspectors found timely and responsive information-sharing arrangements between NPS officers in court and the children's front door to enable identification of safeguarding issues needed to inform sentencing decisions. There is effective training for NPS staff in child safeguarding practice.
- At the initial referral and assessment stage, both YOT and the local authority can identify whether the other is involved with the child or their family through 'The single view' system. This enables key information to be shared across the agencies. A social worker in the YOT has full access to the local authority's electronic case recording system and can download key documents such as chronologies and genograms to inform YOT assessments.
- The YOT has added value to decision-making and interventions for some children, even when they are not formally involved. This includes contributing to child protection strategy discussions where children are involved in sexually harmful behaviour. For some of these children, YOT staff are working collaboratively with the local authority to deliver voluntary interventions for children and young people who have not been prosecuted.
- The engagement of health agencies with the LSCB is good and this is helping to support ongoing development in the quality of their safeguarding practice. This is well supported by the effective work and leadership of the NHS Vale of York



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clinical commissioning group's (VYCCG) designated safeguarding professionals. The designated safeguarding professionals are also closely involved in the governance and oversight of progress against improvement plans which are being tracked by VYCCG. They provide scrutiny and challenge in contract meetings to ensure that services are sharply focused on promoting better outcomes for children.

- Work to progress some of the recommendations from the CQC's 'Children looked after and safeguarding review of health services' in 2016 has taken too long to progress, and work is still needed to strengthen capacity and evidence impact in some areas. However, NHS providers in the local area are now much better positioned to drive forward service improvement. Actions taken to strengthen safeguarding leadership, workforce knowledge and the use of assessment tools are supporting greater levels of confidence and expertise, with good practice now evident in some areas. For example, work with the primary care sector has heightened awareness of the signs and indicators of child sexual abuse, and joint work with midwifery, healthy child teams and the police is now stronger.
- New safeguarding leadership posts in the healthy child team and York Teaching Hospitals NHS Foundation Trust (YHFT) are helping to provide greater levels of support and assurance of the quality of practice and essential guidance to frontline staff who are managing complex casework. For example, the quality of safeguarding practice within YHFT's emergency department is now underpinned by monthly reviews, with tight scrutiny of progress and trends. In addition to this, health commissioners and providers have taken important learning from serious case reviews to promote improvements in their understanding and management of risk. For example, tighter systems for tracking and alerting others to children and young people who have not been brought to appointments are supporting improved recognition of neglect and wider safeguarding concerns.
- Health providers are driving forward a significant workforce development programme to equip their frontline staff and managers with the knowledge, skills and support that they need to appropriately discharge their professional accountabilities for safeguarding children. The shared model of safeguarding supervision adopted by all NHS providers provides a clear and structured approach for driving improvement. Safeguarding supervision is prioritised, and appropriately trained supervisors are encouraging professional challenge and reflective practice.
- The CSAAC service provides a timely, child-centred service to the children and young people who have suffered, or are at risk of, child sexual abuse. The use of play therapists alongside experienced paediatricians helps to make the process feel more comfortable for children.



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- The specialist clinical outreach team (SCOT) meets young people at the locations in which they feel most comfortable discussing their contraception and sexual health needs. This allows practitioners to gather information from children and young people in a sensitive manner, and in an environment which supports positive relationships.
- The police have good working relationships with partner agencies, engage well with the LSCB and are working to embed a child-centred approach in their work with children and young people. The 'It's not ok' campaign is being used well to improve the awareness and understanding of frontline officers. This is complemented by child-centred referral processes that set clear expectations for frontline staff. A strong referral document and its associated guidance is helping staff to focus on children's experiences, and this is enhancing the quality of information gathered. This shows how the force is working to ensure that its staff focus on doing the right things for children and not simply on doing things right.
- The police have invested significant resources in the VAT. This shows that they understand the importance of being better able to identify, assess and respond to the risks faced by children, including child sexual abuse in a family environment. Leadership within this team is effective and dynamic. The unit is working to raise awareness and develop processes to improve the quality of risk assessments and decision-making by frontline staff. This includes providing training to control room staff and conducting dip sampling of referrals. This has significantly improved the quality of referrals, with only 1% now being rejected, rather than 50% 18 months ago.
- When a child is the subject of a child protection plan, the officer who attends the initial child protection case conference is responsible for ensuring that a marker is added to the police IT system on the child and parents' records. This makes good use of the system because it ensures that officers and staff who are attending incidents are well informed about risk. This is positive and would be further enhanced if markers were also added to the address of the child or parents and if more detail was included about the risks faced by a child.
- Processes are in place to ensure that officers and staff are informed of registered sex offenders prior to their release from prison. Safer neighbourhood teams liaise closely with approved premises in the area and have a good understanding of registered sex offenders who are residing there. This process does not currently cover other registered sex offenders within the community, about who local teams could provide regular and important information to support risk management plans.
- Inspectors who sampled investigations into child sexual abuse being managed by the serious crime team found that the team's work was almost always of a high standard, characterised by thorough investigations, timely submissions of



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safeguarding forms and subsequent effective engagement in child protection strategy meetings.

Practice study: highly effective practice

Eight-year-old Sara and members of her wider family have been known to services for many years. Recent good multi-agency work is helping to keep Sara safe from child sexual abuse and to meet her longer-term needs for stability and consistent care. Several years ago, at a time when her speech was significantly delayed, Sara made a disclosure of sexual abuse by a close family member. Charges were not progressed at the time by the Crown Prosecution Service. Professionals remained alert to the possibility that Sara may have experienced child sexual abuse and took seriously a more recent, third party report of similar allegations of sexual abuse. A new social work assessment was completed over several sessions of direct work with Sara, meaning her voice was heard, despite competing adult voices from across the wider family. Following a further disclosure of child sexual abuse to her social worker, a well-attended multi-agency child protection strategy meeting was convened to plan the new investigation. This included the police officer and social worker involved in the initial investigation. As a result, Sara's needs and her family history were well understood. Sensitive planning of the 'achieving best evidence' video interview helped to ensure that Sara's account was captured. This planning included using the support of an intermediary along with tools to aid Sara's communication. As a result, Sara gave a clear account of the sexual abuse she had suffered. Because of this, the arrangements to keep her safe were strengthened. Difficulties in relationships between the adults in Sara's wider family mean that her social worker is maintaining a clear focus on Sara's wishes and feelings in weekly direct work sessions in the home and at school. Additional well-being support in school is also working well to help Sara increase her confidence and her self-esteem.



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Areas for improvement

- When children are the subject of a referral because they may be children in need or at risk of significant harm, this process works well for most children who receive a timely service that is well matched to their needs. During this inspection, inspectors did not find any child at immediate risk of significant harm where this has not been recognised and appropriate action taken. However, services at this early point of involvement with children are not well joined up and any action taken can be sequential, causing cumulative delay in response. Weaknesses in the structures and procedures for sharing information and decision-making mean that, for some children, the full range of their needs and extent of their risks are not identified as quickly as they could be, and there are delays in intervention and in ensuring that agreed actions are followed up. This is because initial decision-making is not always underpinned by the involvement of the right agencies, such as police and health. It is too reliant on the single-agency information and decision-making of the local authority. Securing the right health information and professional input in a timely way is a challenge, particularly in child protection strategy meetings.
- The role and contribution of health providers is not well understood or used to best effect in the children's front door. Accountabilities for co-ordinating a holistic picture of children's needs and contacts with the wider network of health services are not clearly defined. Pathways for ensuring that the expertise of all relevant health professionals is promptly captured to inform joint decision-making are not clearly mapped. The lead nurse for safeguarding (healthy child service) does not have sufficient access to a full range of information systems, and information-sharing protocols are not consistently in place to support this access. Better use of health information and expertise at this early stage, for example the expert resource of the CSAAC, offers an opportunity to significantly enhance the timeliness, quality and impact of the services that children receive.
- While the police VAT team manages large volumes of information quickly and efficiently, opportunities are not taken for the police to contribute at an earlier stage to decision-making and the development of protective plans. Currently, large numbers of referrals are sent to the children's front door without all the relevant police information or an assessment of its significance by specialist staff within the VAT. The inclusion of police information at this stage is an opportunity to enhance early decisions about thresholds and to improve initial protective planning.
- There is limited evidence of criminal investigations into child sexual abuse being conducted jointly with the local authority. When there is an identified child victim, the police generally interview them as a single agency. When there are children other than the victim identified as potentially at risk from the perpetrators, the



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local authority generally speaks to them in isolation. This means that there are potential missed opportunities to gather the best evidence and safeguard children jointly.

- Work to tackle harmful sexual behaviour requires development. Procedures and guidance for staff lack clarity and, as a result, the quality and effectiveness of work and the outcomes children achieve are inconsistent. The partnership has recognised this and, in particular, that procedural pathways to access support and resources need to be clearer. For example, most professionals asked by inspectors were unclear about whether the YOT could provide specialist 'assessment, intervention and moving on' assessments (AIM2) for children who exhibit harmful sexual behaviour but have not received a conviction. This need for service development, such as better provision and clearer pathways, is most acute when children and young people's situations are further complicated by additional needs, such as balancing their needs when they are both a victim and displaying harmful sexual behaviour or when they have a learning disability. Plans are in place to strengthen this work but are at too early a stage to have had an impact.
- Timely access to therapeutic support is increasingly challenging in the face of rising need and a limited resource. For example, one child who suffered a very serious sexual assault had recently been referred for a therapeutic service but is having to wait three months before being able to join the waiting list for a service.
- Although a broad range of data and information is collected in relation to child sexual abuse and exploitation and children missing from home or care, this is currently not analysed as effectively as possible by either the local authority or the partnership. It is planned that the newly appointed social work advanced practitioner for child sexual abuse and exploitation and missing will be reviewing this, supported by the work of a data-analyst, but this is at too early a stage to have had an impact.
- There is a strong commitment to listening to and responding to the voices of children and, in many aspects, this is a key strength of the partnership. However, the analysis of regularly collected feedback or data about children's views and engagement is not consistently rigorous. There are plans to analyse themes from return home interviews, but this has not yet happened. Information about children's participation at child protection conferences is not systematically analysed or used to help improve engagement, and themes from advocacy, beyond the initial reason for involvement, are not collected. These opportunities to inform service development are not being taken by the local authority with the support of the partnership.
- The local authority is experiencing a period of significant turnover in key middle and senior management posts. Vacancies include a quality assurance manager



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and principal social worker. Some posts such as the social work advanced practitioner for child sexual abuse and exploitation and missing are newly appointed to, while the most senior posts are filled on an interim basis. Significant consistency and stability has been maintained in key areas of business during this time, through the full-time or interim promotion of suitably experienced York local authority members of staff. However, this means that progress in some areas has not been as fast or as consistent as the local authority aspires to and that, in a few areas, a lack of consistent scrutiny has led to weaker performance. For example, performance management of the work of the out-of-hours emergency duty team is neither carried out nor aligned to contract management of this service, which is commissioned from a neighbouring local authority. This means that the local authority's ability to assure itself of the consistent effectiveness of this service and to further enhance performance is limited.

- Although most children who go missing are offered the chance of a return home interview take up monitored and return home interviews recorded in their case files, practice is not consistently in line with statutory guidance. Not all children and young people have the opportunity of an interview with an independent professional. This may limit the extent to which some children share information and so hinders work to improve their outcomes.
- In situations when the harmful sexual behaviour of a young person has not resulted in a prosecution, the role of the YOT is not always clear and is sometimes too limited. In such situations, YOT staff are not routinely involved in child protection strategy discussions and in providing interventions. This means that, for a few children and young people, decision-making, planning and interventions are not as effective as they could be.
- Information-sharing between the NHS providers and the healthy child service is weak and progress to address this is slow. This area of weakness is understood by providers and there is a task and finish group in place to address this. Recent developments in information-sharing between the emergency department at York hospital and the healthy child team, and between GPs and maternity services, is helping to strengthen information flows and to enable improved targeting of support to children and their families. However, fragmented access and a lack of timely coordination of two-way information-sharing, including from primary care and mental health services, is hindering effective oversight, coordination and review of the needs of all children within families. For example, work is still required to ensure that the child and adolescent mental health service (CAMHS) promptly shares information with the school health service about children and young people accessing its services.
- Case recording by health agencies, including urgent care and public health staff, requires strengthening to ensure that there is a consistently clear record of the voices of children and of any wider risks that may be relevant to their health and



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well-being, such as their emotional and mental health, or any misuse of alcohol or drugs. Stronger management oversight is also needed of the quality of joint working to ensure a coordinated package of support for children who are victims of child sexual abuse or who display harmful sexual behaviour.

- The school nursing element of the healthy child service has experienced significant gaps in its capacity over recent years, and some posts have only very recently been filled. The team is still at a relatively early stage in establishing its governance and operational procedures and equipping its workforce with the necessary capabilities to effectively discharge their responsibilities. The school nursing service has recently transitioned from the use of paper to electronic records and not all children and young people living in the area are currently identified on the new electronic case management system. This deficit means that work with some children may not be informed by relevant information already held in relation to them or their families.
- The role of the school health team is narrowly defined compared to other areas. This means that children and young people must sometimes approach other health teams for help that could have been provided within the support of the school health team. For example, the team does not provide support for children in special schools or provide contraception or sexual health services. Although good links have been made between one local secondary school and a local GP practice, the effectiveness of local commissioning arrangements, spanning universal and specialist sexual health services warrants further review.
- Some York children and young people wait a long time for specialist assessment and treatment delivered by the local CAMHS service. This is a critical issue that needs addressing to improve access for all children and young people with complex and long-term needs who have been exposed to child sexual abuse or who are displaying harmful sexual behaviour, including those with special educational needs or disabilities.
- Evidence-based tools to assess the needs of children and young people are not consistently used and completed to standard by health practitioners to support understanding and analysis of risk to children. This would improve the quality of referrals into the children's front door and support holistic assessments of children's needs.
- Police investigations of child sexual abuse are not always allocated to staff with the appropriate skills and experience to manage them effectively. This compromises the quality of some investigations. Although inspectors found no children left at immediate risk of significant harm, some children experienced delays in receiving services and the full extent of risks faced by them had not been fully understood. A lack of consistent, robust and meaningful supervision of



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sexual offence investigations compounds this weakness, particularly in those investigations managed by non-specialist investigators. It is positive that the force plans to restructure in early 2019 to enhance its capability and capacity to conduct specialist child protection investigations, but this does not address current weaknesses in practice.

- At present, the police force has Operation Nexus, which looks at wider force governance and processes, but does not have a scrutiny process to undertake a qualitative audit of assessments of practice. As a result, the effectiveness of the commendable work by the VAT to ensure that referrals are submitted in all cases where they are required is being undermined. The VAT itself has been proactive in developing audit and dip sampling but, due to limited capacity, this has necessarily only been reactive, developing in response to specific incidents.
- While most safeguarding referrals from the police are submitted to the children's front door in a timely fashion, for some children this is delayed. In one case seen by inspectors, a referral waited nine days before being sent. This is compounded by the lack of any triage or prioritisation process for police referrals, and limits the timeliness with which the local authority and other agencies can act to address risk and need for this small number of children.
- The VAT research and report writing team are both efficient and effective. However, the initial risk assessment made by the original referrer is not reviewed. If the referrer highlights that the matter is urgent, then the team responds appropriately. However, if additional risks are not highlighted, the lack of a secondary risk assessment by the team means that the referral will be dealt with in the order in which it was received. The impact of this is that indicators of risk can be missed, and delay built into the system.



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Practice study: areas for improvement

For 17-year-old Kyle, who has complex needs, a lack of well-coordinated multi-agency work has meant that the potential risks to his siblings and the wider public from his aggressive and sexually harmful behaviour have not been fully recognised or adequately managed. This is despite a range of professionals being involved. Kyle can at times display aggressive outbursts and disinhibited sexual behaviour; his offending has recently escalated, including further alleged sexually harmful and violent behaviour. A social work assessment of the risks to his siblings, agreed as an action from a child protection strategy meeting, has not taken place. Work, including by child and adolescent mental health services (CAMHS) to identify the underlying causes of Kyle's behaviour and an ongoing YOT intervention, has not been well coordinated. Kyle's current plan reflects his transition to adulthood with a focus on promoting his long-term goals for independence. It has not been updated to address Kyle's increasingly risky behaviour and does not include any interventions to support Kyle's family.

A 'multi-agency' safety plan is in place, but it relies primarily on Kyle's parents keeping him and other children safe. This is insufficient.

Kyle's parents told inspectors they feel 'on their own' and unable to keep Kyle safe in the community. Kyle's new worker has confirmed that their service has no remit to provide support to the wider family, and, at the time of the inspection, there was no date set for any multi-agency planning. As a result, the risks posed by Kyle's behaviour continued to escalate. As a result of the inspection, this has now been brought to the attention of the partnership for action.



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Next steps

The director of children’s services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the NPS, the clinical commissioning group and health providers in York and North Yorkshire Police. The response should set out the actions for the partnership and, where appropriate, individual agencies².

The director of children’s services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 20 February 2019. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	Care Quality Commission
 Yvette Stanley National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	HMI Probation
 Wendy Williams Her Majesty’s Inspector of Constabulary	 Helen Davies Assistant Chief Inspector

² The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/ukSI/2015/1792/contents/made enable Ofsted’s chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.