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Ein cyf / Our ref:

Dyddiad / Date: 17 April 2020

Dear Colleague

Joint Inspection of Child Protection Arrangements (JICPA): Newport, December 2019

Between 2 and 6 December 2019, Care Inspectorate Wales (CIW), Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Probation (HMIP) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect in Newport. This inspection included an evaluation of how local services responded to child exploitation.

This letter outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Newport. Please confirm receipt of this letter to CIWLocalAuthority@gov.wales.

This JICPA included an evaluation of the 'front door' by considering how effectively partners responded to referrals about children who may be in need of help, care and/or support or at risk of significant harm. In Newport, all enquiries or concerns about children are progressed through the local authority safeguarding hub, which is comprised police and local authority personnel. In addition, inspectors undertook a more detailed analysis into the effectiveness of services for a group of children who have experienced or are at risk of exploitation (deep dive). Finally, inspectors evaluated the effectiveness of the multi-agency leadership and management of safeguarding work.

For the deep dive evaluation we reviewed the circumstances of seven children of mixed gender and ethnicity, aged between 13 and 17 years old, three of whom were care experienced children. The deep dive methodology included two focus groups comprising the range of multi-agency professionals working with these children, an evaluation of information held across agency databases, and interviews with children, parents/carers and professionals. Inspectors primarily evaluated work with children and their families based upon the last six to twelve months of agency involvement. A survey was administered to local authority and youth offending service staff.

Our main findings in relation to partnership working are outlined as follows. During our inspection we met with highly committed and motivated professionals who demonstrated a good understanding of the nature of work in relation to children and families who are at risk or are experiencing exploitation. We recognised the complex nature of this work.

Inspectors found the police and local authority have worked together to co-locate personnel at the safeguarding hub. This enables shared information and improved and timelier decision making. The arrangement would be enhanced with an improved interface between the hub and health and

education representatives; for example if these agencies co-located and worked alongside police and social care colleagues outcomes for children and families could be improved. We did not see evidence of a review of the hub partnership or of a performance framework in place to help understanding of how the hub delivers a safeguarding service. There is no clear audit programme that would reassure leaders their expectations are being met. The partnership therefore cannot be fully assured it is improving the safety and outcomes for children and young people.

We found the regional safeguarding board was coherent in the organisation of business and was well supported by the multi-disciplinary group. The adult and children's boards have recently merged, this will have benefits in sharing cross cutting information and shared learning. The Newport local authority safeguarding lead has a high profile and is actively engaged and leading on elements of regional safeguarding work. The chair of the board has acknowledged the need to develop an approach to quality assurance of safeguarding work to be confident partners know what is happening in the delivery of different elements of operational safeguarding practice. This is critical for the partnership to be reassured about safety and outcomes for children and young people. A multi-agency training sub management group delivers a programme that is well received by partners.

With regards policing we found clear indicators of improvement since the latest Gwent National Child Protection Inspection; we were particularly reassured to see Gwent Police forces' co-ordinated adoption of trauma-informed practice and Adverse Childhood Experiences (ACEs) work.

There is a comprehensive prevention offer in Newport, both at youth justice level and children's services. We found strong support in this area from the Gwent Police and Crime Commissioner who is represented on the regional safeguarding board. Partner agencies (both statutory and 3rd sector providers such as St. Giles, Barnardo's and Newport Live) are working to a shared ethos of safeguarding children and young people at different levels of vulnerability. This is evident as leaders within these organisations articulated a clear and shared vision.

Partners recognise broader facets of abuse and exploitation, and are working together to protect children through activity to disrupt organised crime gangs. Before enforcement takes place, the police share information so schools and children's services can plan for disruption to children's day and offer support where necessary. A nominated safeguarding officer is part of each team executing search warrants. They are briefed about reporting any concerns about children immediately. This ensures prompt protective plans are developed to support the children that are affected. Operation Encompass is another example of effective partnership; this allows schools to be informed about domestic abuse incidents that have occurred and enables a school representative to engage with the family and support the child.

Partners have instigated a Gwent Monitoring and Review panel to improve the well-being of children detained in police custody. This has successfully agreed a protocol to make sure appropriate adults attend the custody suite to support children's welfare. Increased oversight has also seen the number of children detained overnight decrease.

Local authority departments, on the whole, work effectively together when in contact with vulnerable people. For example, we found housing officers participating in safeguarding forums such as Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conference (MARAC). There is mandatory safeguarding training for local authority staff.

Agencies have worked together to develop a Child Exploitation Assessment tool which is a combined Child Sexual Exploitation (CSE)/Child Criminal Exploitation (CCE) tool. The tool should facilitate an excellent opportunity for professionals to collaborate, share information, evaluate risk via the multi-agency group and develop plans to mitigate risk. This is currently being piloted and will require validation.

Senior education leaders, at all levels, communicate effectively. A clear and collaborative vision for the schools across the authority ensures a safe and consistent learning environment for vulnerable pupils as well as a wide range of high-quality learning experiences. Newport's multi-agency approach to supporting and safeguarding vulnerable pupils who receive their education in Welsh-medium schools, however, is reactive and not strategic enough. The more recent plans within education demonstrate improved provision and a stronger commitment to providing support for these pupils in Welsh and the intention is a positive step forward. However, there continues to be a lack of parity between safeguarding vulnerable pupils in English and Welsh language schools. As a result, vulnerable pupils who attend Welsh-language schools do not always have access to required support through the medium of Welsh.

Operation Quartz and the Multi-Agency Child Exploitation Meeting (MACE) provide opportunity to oversee and coordinate work with children who are vulnerable to potential exploitation. Local authority operational staff told us the MACE meetings could duplicate process. The terms of reference for the MACE forum should be reviewed, this is opportune as plans are in place to consider both young people at risk of CSE *and* CCE.

The Missing Persons Team (MISP) team is under review. We found there is no clear understanding of the future and how functions will be absorbed in to a future model. The debrief or return interview is a critical area of safeguarding practice and any changes need to be communicated across partners and implemented effectively both in interim and longer term arrangements.

We received varying accounts with regards the consistency of attendance at child protection core groups for some professional groups. In the absence of a clear auditing framework, the partnership agencies cannot be reassured all agencies are effectively contributing to the analysis of risk and the development of care and support safety plans.

Key Strengths

The police force demonstrates a clear commitment to child protection, in particular to tackling exploitation of children in Newport. This is highlighted as a force priority through the Police and Crime Commissioner (PCC) police and crime plan and by the production of CCE problem profile to better understand the issue. The PCC has also funded a pilot so a social worker is present in the control room to provide access to social services information. This senior social work practitioner can also provide advice and guidance to staff dealing with vulnerable children, although it is too soon to assess the impact of this post.

The force have made significant investment to make sure the team responsible for investigating child abuse is fully staffed. Officers have been provided with specialist child abuse investigator training, as have their supervisors. They are supported in the investigation of exploitation by the Operation Quartz team. This team is also fully staffed with a dedicated detective sergeant responsible for managing the activities of the team. This means those children who are at risk of exploitation see officers from the same team who know their circumstances well. Team members attend exploitation strategy discussion, and the investigation of exploitation offences are conducted by those with specialist knowledge.

Through the early action together programme the force has trained 1,100 front line, custody and control room officers and staff in awareness of ACEs and being trauma informed. This has been supplemented in Newport with additional workshops for 130 officers and staff to improve Public Protection Notice (PPN) submission with associated aide memoir and a guidance template. This has seen an improvement in the quality of information being shared with children's services. The force has improved the training provided to custody staff, including health care professionals so broader safeguarding issues are recognised and reported through submission of PPN's.

We found managers at Aneurin Bevan University Health Board (ABUHB) committed to improving practitioners understanding of their individual professional responsibility towards safeguarding and protecting vulnerable people. All areas of ABUHB have individual representation on the internal safeguarding board, which provides a level of internal scrutiny. The ABUHB Corporate Safeguarding team submits relevant reports to this board. A safeguarding paper is presented to the Quality and Patient Safety Committee annually, and safeguarding is an agenda of this committee. ABUHB Safeguarding Committee has an external chair with an extensive safeguarding background. This assists in providing independent oversight and scrutiny. The ABUHB intranet has a corporate safeguarding page giving all staff access to useful advice and guidance. Internal and external contact details are also available for practitioners.

We were told about progress to consult with young people; ABUHB was recently awarded a National Children and Young Persons involvement and engagement award by young people. The children's ward at the new Grange University Hospital has been developed taking into account the views of young people.

Staff we interviewed identified the corporate safeguarding team are accessible for advice and guidance. The implementation of local safeguarding champions in different areas has extended the support network further. The corporate safeguarding team develop and deliver all levels of safeguarding training including face to face sessions in specialist areas of the field which are well attended. Levels of compliance in this mandatory training have increased significantly.

The children's services senior manager group is a relatively newly established group, but was coherent and visible across the workforce. We found children's services senior managers communicate effectively with their staff, there is a supportive, open and non-blaming culture set by the head of service. This means practitioners feel 'safe', with sharing of risk decisions. Newport is a learning organisation; innovative thinking was recognised and managers were actively testing new ways of working. An example of this is how Newport children's services is changing how children's homes support young people. There is a strategy (supported by members) to enhance the internal residential children home provision. This has included an approach to overhaul the home environments. We saw some good examples of how residential staff work effectively to engage and interact with young people.

There was effective joint-working between school leaders through established groups such as the 'managed moves' group, and more recently, the involvement of multi-agency leaders at the 'School Exclusion and Exploitation Partners' group and the 'Serious Organised Crime' group. These initiatives complement and support the authority's vision very well in protecting children who are at risk of exploitation.

Officers in the authority's Engagement and Inclusion Team work very closely with school leaders to provide worthwhile support for school-based staff. All school staff receive appropriate and high-quality training in approaches to support pupils' social and emotional development. Following robust quality assurance reviews, training has included a valuable focus on understanding threshold requirements for action when completing multi-agency referral forms as well as preventative training through the Attachment Awareness Programme. This training includes appropriate support for staff to respond to issues such as the impact and trauma of bereavement, anger management and pupil self-esteem. Local authority leaders ensure training gives school staff the confidence and skills required to implement the authority's vision successfully. As a result, school staff at all levels show an outstanding commitment to the vision and implement it enthusiastically.

Managers of the local authority's education inclusion team provide a high level of challenge and support for school leaders. They are frequent visitors to schools and attend key strategic group meetings. In terms of establishing robust systems for reducing the risk of exploitation, they know the schools' strengths and areas for development well. They evaluate the impact of intervention

effectively and act upon the outcomes so the personal development plans for children at risk of exploitation are implemented and reviewed regularly.

There was a youth peer review completed last year which identified a number of areas of development for youth offending services. Many of these have been actioned, most significantly the reframing of the management board, which in both previous HMIP inspections and the peer review was found to be ineffective and unwieldy.

The Youth Justice Service (YJS) has access to good information about the service it delivers and the information manager provides information to the board and team managers to help scope service delivery. This information identifies nearly two thirds of open YJS caseload has either child criminal exploitation or sexual exploitation as a factor in their offending. In addition re-offending rates from community resolutions are known, and first time entrant rates for prevention cases. This should allow the evaluation and review of these schemes.

There has been work to reduce children sentenced to custodial sentences and this has been effective, with no children from Newport currently in custody.

A Health Care Professional (HCP) is permanently available in police custody suites so all children that are detained can see the HCP. Custody staff and HCP's have received training in CCE issues and Adverse Childhood Experiences (ACE's) and are able to make an assessment as to whether it is likely the child is being criminally exploited. This information is recorded on the PPN when submitted to the local authority. This means essential information is available at source which is important to facilitate prompt decision making. In November, 42 children were detained and PPN's were submitted in relation to 41 of them.

There is a good offer of interventions following a community resolution, and a clear policy in place with the police on the number of community resolutions a child can receive. This follows a brief consultation between the YJS police officer and an YJS team manager. YOS Staff have received training on safeguarding and a number of staff have also received training on being a 'first responder' to human trafficking.

At the time of our inspection, the National Probation Service (NPS) and Community Rehabilitation Company (CRC) offender management functions came together in a new unified model under the National Probation Service. This significant undertaking progressed smoothly.

All staff are required to attend the NPS single agency safeguarding training, and this is supplemented by attendance at the Gwent Regional Safeguarding Board multi-agency training. A probation officer is part of the board training sub-management group and helps deliver the training programme. Feedback from the recent county lines event, facilitated by the police, was particularly positive.

We identified a consistent and well understood process for professionals to refer concerns about children to the safeguarding hub through the completion of the Multi-Agency Referral Form (MARF*)* or in the case of the police, Public Protection Notice (PPN) forms. The MARF clearly guides the referrer through the provision of information to ensure the information provided assists the decision-making process and ensures consistency in the referral process.

New referrals were processed in a timely manner and relevant "core data" including whether or not assessments have been offered in the Welsh language was captured on children's records. At the safeguarding hub we saw evidence of strategy discussions taking place and Section 47 enquiries being commenced promptly. There are twice weekly hub meetings which screen relevant referrals with information provided by partner agencies. Agencies present then contribute to allocation decisions. During the inspection we had an opportunity to observe a meeting and found it to be an

effective process. As highlighted earlier however, there is opportunity to enhance the decision-making process through improved multi-agency input.

When a decision is made to take no further action in relation to PPNs received at the hub, the Early Intervention Team reviews these referrals. Contact is made with the family the same day with an offer of a “What Matters” call in two days and then a further visit if appropriate. Any concerns identified by this team can be escalated back to the safeguarding hub via the Welsh Community Care Information System (WCCIS) system. There is ambition to include the MARF referrals into this process. In only 7% of cases was a re-referral made for these children and families and only 6% of cases were escalated back to the hub. This is an indicator this system is working effectively to identify and prevent needs escalating.

Police staff in the Early Intervention Team and the hub quality assure PPNs received. They give feedback to officers and their supervisors. Themes are identified and reported to the Early Action Together Board so training can be reviewed and updated. The Early Intervention Team hold a weekly Space Well-Being Panel. Families First also facilitate a multi-agency meeting that reviews all referrals which are referred/self-referred for Advice & Assistance. This ensures a partnership approach to agreeing a range of preventative interventions to support families. There can however by a delay of 3-4 weeks following allocation for work to commence.

Preventive services through Families First funding are providing “out of hours” outreach/keep safe work with young people at risk of exploitation; as well as sharing relevant intelligence and contributing to strategy meeting decision making with police and social services.

The St Giles Trust, Divert and Barnardo’s workers have been commissioned to provide diversionary preventative services to children who are at risk of criminal exploitation. Projects focusing on serious organised crime and early intervention are well established and provide practical and peer support to children who have been identified as being at risk. We found project workers provided lived experiences to enhance the work and provide valuable contribution to CCE strategy meetings.

The School Exclusion and Exploitation Partnerships Group is a multi-agency panel. This group meets half termly to explore the correlation between school exclusion and young people’s engagement with criminality. This group has been created as a sub-group of the Youth Justice Service board in Newport, with the aim of sharing information and research between partners to explore correlation and identify effective interventions. We found joint decisions on pupil placement, referral and intervention support being informed by effective research focused on contextual safeguarding. All partners showed a comprehensive understanding of the need to respond to young people’s experiences of significant harm beyond their family or home environment.

Child and Adolescent Mental Health Services (CAMHS) have processes in place to respond to children and young people with complex needs in a timely manner. We found evidence of CAMHS staff making follow up telephone calls to families when young people had not been brought to appointments. This persistent approach is particularly important when working with young people who may be reluctant to engage.

Gwent Police have recently introduced CCE functionality within the well-established Operation Quartz team. This is a significant investment and is intended to streamline processes so the teams become omni-competent to deal with child exploitation holistically. Whilst the CCE team are becoming established and analysing pre-existing information about which children may be at risk from exploitation there is a large cohort of children under consideration. However, this should become more manageable as the newly developed child exploitation assessment tool is applied to each case and those at most risk are protected through the development of joint protective plans.

The authority has developed a successful network of support offered by highly motivated learning coaches who support individual pupils at school. Employed and line managed successfully by the

schools and PRU, they engage enthusiastically with pupils to provide positive experiences of the world of learning and work. They work with individual learners to provide consistent mentoring to support learning. This regular support helps pupils negotiate with teachers, work placement managers and care home staff to manage their coursework and social activities appropriately. The learning coaches play a valuable befriending role in supporting them to make positive life choices and succeed with their education. They work closely with the authority's Looked After Children Co-ordinator (LACE) to ensure important information about the pupils' wellbeing is transferred between children's services and education in a timely manner.

School representatives are key contributors at safeguarding core meetings and looked after children reviews and when necessary, school representatives make every effort to attend meetings held out of term time. If schools cannot attend, the authority makes appropriate arrangements for senior officers from central education services to attend. This ensures that at these meeting, the pupils' education needs are integral when considering support and intervention.

The 'Team around the Bridge', which consists of multi-agency professionals, offers appropriate support for pupils at the PRU to reduce the number of persistent non-attending pupils. This carefully selected group of educational professionals offer worthwhile coordinated support for pupils and families at risk of exploitation or who are currently named on the child protection register. The 'Team around the Bridge' provides an appropriate focus on developing pupil voice through the 'Learning Well' plan. This increases pupil participation through gradually increasing the timetable to include leisure activities. Staff also benefit from half termly 'clinics' held by authority's behaviour officers and educational psychologists. These informal events enable staff to raise concerns that lead to further training and professional learning for all staff.

Probation court staff undertake timely safeguarding checks on all cases where it is known there is a child present at the address when a Pre-sentence report (PSR) is requested. These are responded to promptly by the safeguarding hub and this information is provided in sufficient time to enable sentencing. For cases that do not have a PSR, safeguarding checks are completed at the start of assessment as part of the induction process by probation. This has been seen in the cases inspectors sampled.

There is a clear process in place for checks to be made by the safeguarding hub to probation, with a generic email box utilised which provides resilience if certain workers are away. Probation officers are on a rota to respond to these requests.

YJS staff now attend the twice weekly hub meetings and provide information on YJS cases, which improves communication and enables a holistic approach to decision making. YJS staff can also have 'read only' rights to WCCIS system which also facilitates prompt sharing of information, although not all staff had access. Lateral checks (contact and liaison with agencies) are undertaken with all relevant agencies at the start of an intervention for the purpose of an YJS assessment. There is an offer of intervention for community resolution cases which are referred to the YJS. There has been a recent YJS staff briefing event on the role and scope of children services and this was well received by staff; their feedback indicated this enhanced their understanding about the process for improving outcomes for children.

Where safeguarding concerns/exploitation is identified we noted exploitation strategy discussions and meetings being convened. We saw a clear distinction between strategy discussions and formal strategy meetings. We saw good examples of multi-agency communication and interventions leading to preventative measures being implemented, such as child abduction warning notices served on persons posing a risk to children.

We identified a wide range of services to support children and to meet individual needs. There is significant multi-agency professional investment with children and their family characterised by

information sharing and challenge. Despite the challenges of working with complex circumstances, agencies were not deterred from identifying interventions, offering services and working to achieve positive outcomes. We saw evidence of effective multi-agency working, professionals were positive about partner agencies and working relationships and displayed a commitment and drive to improve outcomes for children.

We observed a multi-agency exploitation meeting where there was good representation of professionals and evidence of multi-agency collaboration regarding the new exploitation measurement tool. Although this is currently being tested via a pilot, early indications show this gives the opportunity for information sharing and collectively agreeing the level of risk.

Children told us they had been able to form good relationships with professionals working with them from across a range of agencies. We were told about some social workers having long standing relationships with young people. Research points to the importance of young people having strong relationships with a key individual[1], so this is a significant finding.

We found consistent use of the acronym CWILTED was observed in all but one of the A&E attendances of the seven children we reviewed. This information was recorded at triage, so all health practitioners who were subsequently involved in the care of the child were aware of the Complaint, Who the child was With, Incident that occurred, Location of incident, Time incident occurred, Escort in A&E, and Diagnosis. This information was obtained promptly, since triage of the seven children reviewed occurred within 26 minutes or less of attendance in the department. Information regarding risk was shared promptly and appropriately between health disciplines, allowing for timely interventions to take place and the level of risk reassessed.

Health professionals were noted to be adopting appropriate professional challenge, this was an indicator this staff group were confident and competent in safeguarding practice. Health staff actively encouraged engagement of families with services. We have noted the availability of sexual health outreach workers to undertake both one to one work and bespoke group work at schools. We observed the GP record system to provide alerts to safeguarding involvement immediately on opening a record. This provides an important prompt for GPs to consider and check safeguarding background information.

During the examination of police information in the deep dive cases we found consistent understanding of risk and prioritisation of response in the force control room. All the children were flagged on police systems appropriately highlighting risks and vulnerabilities. Control room staff research information held on databases to assess risk including MIRAF. The children in the deep-dive cohort reported missing are always assessed as medium or high. In one case the Quartz Team maintained a master-log of events and activity which unlike the MIRAF is accessible to all police staff and includes current Quartz and social care status, investigation updates, multi-agency referral information and MACE minutes.

The Police make use of child abduction warning notices (CAWNs) to restrict perpetrator access to children and provide further safeguards. This is good practice where other interventions are not possible. Police systems are flagged with details of CAWNs and this provides an immediate line of enquiry when the child is reported missing. In the cases where CAWNs are in place we saw this information relayed from control room to attending officers. However, it did not always result in attendance at the perpetrator address. The inspectors saw an example of a CAWN used which

[1] https://www.cardiff.ac.uk/news/view/children-at-risk-of-sexual-exploitation-need-better-support,-report-concludes

resulted in the offender being arrested and convicted for child abduction, he was also later served with a Risk of Sexual Harm Order and is now being managed as a level 2 offender within MAPPA.

The local authority have a responsibility to provide appropriate accommodation to children in order to prevent the unnecessary detention of children in police custody overnight. Where accommodation has been requested and the local authority is unable to fulfil those obligations, police refer the individuals to the Gwent Monitoring and Review Panel for discussion with a view to improving outcomes for children held in custody.

We found enthusiasm and commitment amongst the children's services staff we have spoken to and a professional persistence in efforts to build relationships and engage with children and families. We found specialist advocacy support is being provided to meet the needs of individual children.

Children's services managers have taken a lead in the co-ordination and leading of the exploitation tool and model. This is a new approach which is generating wider interest, however, it is too early to evaluate the impact of the new system in promoting shared understanding about risk and safety planning.

YJS have a standing representative at MACE meetings which improves information sharing and strengthens intelligence gathering to better manage the risks. YJS practitioners work hard to establish and maintain effective working relationships with children at risk of offending or reoffending. They have a commitment to attend various professionals' meetings to better understand and manage these risks. The child's voice is evident throughout most of the files and their views considered appropriately. We found good relationships within the Youth Court and CPS have enabled appropriate adjournments to seek diversion from court and successful applications for early revocation of statutory orders were this is in the best interests of the child.

Overall there is good joint working with partners and information sharing evident from probation. This has a positive impact on the safeguarding of children but also provides the Offender Manager with an insight into the wider context of their service users. Safeguarding checks are undertaken by the NPS at the start of intervention with prompt follow up and liaison with children's services. Swift responses from agencies to these requests from NPS were also seen.

The local authority has developed excellent information sharing arrangements between English mainstream secondary schools and the PRU when pupils transfer from one setting to another. Pupil transfer and transition is co-ordinated successfully through the well-established Managed Moves panel. The group engages openly in an established culture of honest dialogue, trust and transparency. Senior managers from all eight English medium secondary schools and the PRU attend weekly meetings. They are joined by local authority officers, the Education safeguarding officer, LACE co-ordinator and the youth justice service. This panel, which works to reduce exclusions through collaborative working, provides very worthwhile opportunities for detailed and robust discussion on pupils who currently receive intervention either at mainstream school or attend the PRU. This includes robust challenge to evaluate the possibility of re-integration for the pupils to mainstream education as well as open and supportive dialogue about moving pupils from one mainstream secondary school to another.

During these evaluations, all senior members consider wider contextual safeguarding issues such as the potential damaging effect of integrating certain pupils with other vulnerable pupils at the school. When this arises, managers are open to establishing a flexible, reduced timetable to minimise the risks. The panel also share valuable intelligence and information on pupils when considering permanent and fixed term exclusions as well as school admission referrals. This panel

ensures the needs of the pupil are the focus of any intervention and is having a significant effect on reducing the risk of exploitation.

The group have recently established a Managed Moves protocol for Primary schools that focuses on upper key stage 2 pupils, however it is too early to evaluate the impact of this on the schools' role in reducing the risk of exploitation. The local authority ensures primary school leaders engage in valuable child exploitation awareness activities through early identification systems and the heathy schools initiative that focuses successfully on emotional and sexual wellbeing as well as social relationships and the negative effects of drug and alcohol.

The authority has well established strong partnership work involving Coleg Gwent and a range of satellite provisions that support vulnerable learners who follow post 16 learning pathways. These include working towards qualifications in the Leisure and Tourism industry as well as vocational courses in car mechanics and hair dressing. This strong partnership is supported further by St Giles Trust, Barnardo's, Newport Live and the youth justice team. All partners have developed exceptional, individual early interventions and support plans for vulnerable pupils affected by gangs and serious violence. The programme engages successfully with pupils and their families to offer positive activities such as boxing, fishing, gardening and football. These timetabled activities help pupils develop important social skills that enable them to make informed life choices and decisions.

Through the sample of files we reviewed we note the local authority has developed effective arrangements with youth justice and social workers to provide support and guidance for a family who has English as an additional language. Regular translation from Amharic to English is provided for key meetings to ensure both parents and pupil understand and engage appropriately with the individual education plans created. This high level of engagement with the family, results in an informed buy-in from the school and family that leads to meaningful multi-agency working that focuses primarily on meeting the educational needs of the pupil.

We noted effective use of 'Class Charts' in one secondary school. This is an internal electronic system that was initially introduced to enable staff to log and record any wellbeing concerns about individuals. Recently, the school has started to record positive observations on a vulnerable pupil. As a result, staff are aware of the positives and regularly celebrate the pupil's successes. The school's innovative use of this record gathering system contributes significantly to the pupils' self-esteem and her willingness to conform to acceptable behaviour. As a result, the pupil has remained in the mainstream school and her attendance has improved from 43% in 2018-19 to 86.7% this academic year. She has also received 69 positive flags from staff across the school and only 29 negatives since September.

Areas for Improvement

Although dip sampling of police cases does take place this still focuses on compliance with process and investigative outcomes rather than the quality of practice and how that affects outcomes for children. The force does not undertake routine internal safeguarding audits to assess the nature and quality of operational practice when vulnerable children are encountered. Senior leaders therefore cannot be certain officers and staff are consistently making the best decisions for vulnerable children. The force needs to do more to check decisions being made about children are in line with their expectations. Recording of outcomes of multi-agency working or protective planning is inconsistent on police systems. This means officers deal with incidents when they do not know all the information the force holds on a child. The consequence of this is decisions may be flawed and result in the development of less effective protective plans.

We were told young people have been placed in temporary bed and breakfast accommodation without adequate checks being undertaken with housing officers regarding the safety of the accommodation. This has potential to place already vulnerable young people at increasing risk.

We found a positive relationship between Independent Reviewing Officers (IROs) and social work teams, a balance of healthy challenge was noted. The IRO workload, however, is very high, they report this is impacting on the quality of their work. This is not something we have covered in depth at this inspection in terms of impact on outcomes for children and young people, but we were told the IRO capacity to fully represent the child's position through the looked after children review process was impacted.

Newport's multi-agency approach to supporting and safeguarding vulnerable pupils who receive their education in Welsh-medium schools is too reactive and is not based well enough on planned strategic considerations. To exemplify this, a pupil at risk of exploitation who received his primary education through the medium of Welsh, recently transferred from a Welsh medium secondary school to an English medium school. This was partly due to the fact there was no alternative specialist provision available through the medium of Welsh. The authority's Welsh in Education Strategic Plan published in December 2016 has identified the need to improve Welsh-medium special education needs provision. However, although recent plans address the needs to provide specialist support in Welsh-medium primary provision, this remains a significant shortcoming and there continues to be a lack of parity between the support available for pupils in English and Welsh medium provision.

The YJS has a specific role for working with Children Looked after and this role works to the Protocol for Looked After Children. This role and protocol has not been reviewed for a number of years and the role has drifted from the original vision. This protocol and role needs reviewing. There is not a consistent approach to case recording for this role, some records are not available on a shared database. Some data about children who are not offenders is stored on the youth offending database. The role has been developed to support restorative approaches in the children's homes, but there has not been restorative facilitators training delivered to staff in children's homes for 18 months. The protocol is currently subject to review.

The transition process for young people working with the youth offending service that are reaching 18 needs reviewing. There is potential to make better use of the seconded probation officer to hold, or co-work these cases until they are ready to transfer, and then the seconded probation officer retaining the cases. This would minimise changes of personnel and promote consistency for the young person. This is challenging with the probation officer part time in Newport YJS and located at a different probation office. The YJS seconded probation officer is not able to access probation information whilst at the YOT office, this can lead to delays in accessing risk information which may have an impact on safeguarding children.

There is a confusion in the pathways and recording of cases identified as prevention cases in the YJS, with no clear start and end times for this intervention and cases potentially staying open for long periods of time. Children will often remain at some risk of re-offending with there being no expedited exit planning for these cases. Probation staff are unclear about when to use the maturity assessment on the young people on their caseload. For probation, there is an expectation home visits will be undertaken in a timely manner on all cases where there are children present. This has not always happened in the cases sampled.

Police and children's services staff are committed to providing a joint approach to responding to safeguarding referrals and have allocated resources to deal with the volume of referrals received. However, as not all agencies are represented at the hub, this can inhibit the promptness and quality of decision making. Requests for information from partners in relation to the hub meetings are sometimes sent out late which can exacerbate this problem. We noted there are some delays in the processing of PPN notices when information is missing or due to IT issues, the form has not been

received. Police staff resilience can sometimes lead to a delay in rectifying this and a backlog in processing referrals. This means help to children and families can be delayed.

There is a lack of feedback to partners about outcomes from referrals except in relation to the PPN's being managed by the Early Intervention Team. This means professionals are not aware of what has happened in response to their concerns and potentially dissuade them from submitting referrals when they are required in the future.

When safeguarding referrals are received in relation to files open to social work teams we found there can be a delay in attaining a prompt response from partners to ensure a timely strategy discussion. The Gwent Police central referral unit (CRU) is a regional team and volume pressures can lead to a delayed response.

The quality of referral information received in to the hub from partners is variable. We found whilst detail can be provided, the quality of information about specific safeguarding concerns is not always explicit. It is of note however, PPN forms received from the police are improving in quality, including information recorded about the voice of the child and the recognition of ACEs. The local authority are initially responding to all referrals within 24 hours. Lateral checks are taking place in most cases. However, these checks frequently lack enough detail to provide a meaningful contribution to assessments. For example, we found checks conducted with agencies may enquire as to their current involvement, but often limited other information was recorded.

Whilst referring above to positive practice in relation to PPN forms being submitted for children detained in custody, this is causing duplication as PPN forms are also being submitted by the officers dealing with the incident/making the arrest. This is contributing to the volume of police PPN referrals being processed in the safeguarding hub, possibly causing confusion and leading to help for children being delayed. Completion of PPNs is not consistent across the cases reviewed. Whilst in the main there are forms completed for children where safeguarding concerns are present and when children are arrested; they are not always completed when children are reported missing. It is therefore not clear whether information about the circumstances of the episode and associated risks has been shared with relevant safeguarding partners nor whether partner interventions have resulted from referrals.

We found assessments did not always record children had been seen nor their views incorporated. Whilst we recognised social work practice to positively engage with children we did not find this reflected adequately in documentation. Further work is required to fully embed the principles of the Social Services and Wellbeing (Wales) 2014 Act and strengths-based practice. Assessments reviewed in children's services did not incorporate information about what matters to children nor the outcomes children and families wished to achieve. As "What Matters" conversations were not evidenced so the voice of children and families was poorly represented. Assessments were not concise and lacked analysis. We saw several cases where there was a clear indication (through multiple recent re-referrals) children and families were in need of care and support but their situation was not progressed appropriately.

Some care and support plans inspectors reviewed included clear objectives and goals in relation to outcomes for children, with scores assigned so that progress and development of children can be tracked. WCCIS records, however, were not always individualised and pertinent to a child or sibling; this made it difficult to ascertain whether there was a clear focus for individual care and support plans when specific interventions were being undertaken with children and family. Care and support plans were not always comprehensively completed. They did not demonstrate work undertaken by involved professionals was effectively co-ordinated. Plans were not consistently updated in a timely way following significant changes, for example when children become looked after or return home. It is not clear whether children have contributed to their care and support plans or whether they have been invited to meetings. The review of files indicated children are not always referred for

advocacy services. Staff would benefit from further training on CSE and CCE to develop confidence and skills with regard to this area of work in order to best meet children's needs.

We found written agreements being used with families as an alternative to using child protection processes. This approach has potential to undermine multi-agency working, minimise risk and does not provide children and families with clarity about what is expected of them or why.

Within the files we sampled we saw significant delays in holding CCE strategy meetings. This means there are delays in conducting a multi-agency risk assessment. Although an initial strategy discussion had taken place to discuss immediate safeguarding considerations and flags had been placed on police systems, the delay in progression to a strategy meeting to share information, assess the ongoing risk and formulate a plan left these children potentially exposed to ongoing risk. We found missing children strategy meetings were not convened in line with All Wales Guidance The local partnership cannot therefore be reassured that for missing children an assessment of risk and safety planning is robust.

We were told by different professionals minutes of strategy meeting were not usually circulated or were delayed in being sent out. Without a meeting record distributed, there is concern that a common understanding of the identified risks and actions being taken will be miscommunicated. Professionals were not always invited to attend strategy meetings and core groups when they would have valuable information and intelligence to share. This could result in children not always being adequately safeguarded. Conversely, local authority staff were concerned some agencies were inconsistent in their attendance at core groups. Key professional representation at core groups is imperative as this is where the detailed child protection plan is formulated and reviewed.

Inspectors concluded the response to section 47 enquiries was varied, some investigations were well-managed and had appropriate supervisory oversight. Good examples of joint-working with investigative and safeguarding considerations clearly identified and addressed were seen.

Where children are reported missing; activity to locate and safeguard them was not always pro-active or timely. Other competing policing priorities lead to resource issues and often initial enquiries are telephone calls and database checks. Opportunities to capture the voice of the child in interactions with police was varied. In some investigations it was particularly good with use of body worn cameras, specially trained officers, joint-visits with social workers and intermediaries. Often the demeanour and appearance of the child is recorded as well as a description of the living environment. However, a review of the records of interviews when a child is located or returns home after being reported missing, revealed detail documented from the interview is either brief or not present at all. In some cases, there was little curiosity, consideration or investigation of wider safeguarding considerations particularly in a case where an offender was not residing in the Gwent Force Area.

Management oversight in the files we reviewed was consistent, but not always sufficiently effective in terms of the recording of challenge and quality control of decision making. This results in a lack of rigour and a missed opportunity to improve the variable quality of referrals and assessments.

Open YJS cases are not flagged as open on the children's services case management system, and the safeguarding hub does not have access to the YJS case management records. This hinders efficient information sharing and delays communication. YJS cases can stay open for indefinite periods of time, subject to management agreement, on a voluntary basis. This could have the effect of creating a false reassurance of safeguarding from children services where the intervention is minimal or disengaging. Some YJS staff were confused as to which assessment tool to be completed on CR cases, whilst there is guidance provided when to use the full Assetplus assessment tool, or the Newport in house shorter assessment, staff were unclear about this and in one case seen no assessment was completed.

YJS plans do not adequately reflect the work of other agencies to manage children's safety and well-being. Exit planning was variable. In some records there was no formalised YJS assessment of current needs to inform a plan of intervention. Referrals were made via the Protocol for Children Looked After (PCLA) as part of an exit strategy following ending of YJS statutory support in some cases which affords the children some continuity of support. However, there is a lack of focus to this and very little formal recording was seen on the YJS records in terms of the nature of the support offered or received. Whilst the service offered is child focused and support is offered in terms of their wishes, it is not integrated into other plans for the child and there is a lack of co-ordinated approach for those children.

The probation service had not always shared all relevant previous offending with professionals to better safeguard children and ensure risks are appropriately managed. Information should also be provided promptly to the child's social worker and YJS concerning court outcomes to inform any contingency planning that may be required. Probation staff would value further training on the processes and legal terminology in relation to safeguarding. They feel this would add value to their ability to complete MARF forms and better represent young people's circumstances.

Inspectors found health documentation did not prompt staff to make enquiries about essential information; whether there is children's services involvement with a family and who has parental responsibility for the child. Body maps to enable practitioners to document injuries were not routinely used. MARF's submitted by health did not always include details of parents and siblings. For one file reviewed there was no evidence a referral was submitted in relation to a child who attended A&E after an overdose.

We found no evidence of GP attendance at child protection conferences for the sample of files reviewed by health inspectors, although wider health professionals were noted to attend.

An area for development for the education department would be to ensure the managed moves panel is extended to consider fully the challenges of vulnerable pupils who attend the Welsh medium secondary school, Ysgol Gyfun Gwent Iscoed.

Next steps

The local authority 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 National Probation Service, Youth Justice Service, Aneurin Bevan University Health Trust and Gwent Police. The response should set out the actions for the partnership and, where appropriate, individual agencies. The head of service for children's services should send the written statement of action to CIWLocalAuthority@gov.wales by *Date to be agreed*. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

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