Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Iau, 13 Mai 2010
Thursday, 13 May 2010

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Irene James	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Jonathan Corbett	Prif Arolygydd Cynorthwyol, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru—Rheoleiddio ac Arolygu'r Gwasanaeth Assistant Chief Inspector of the Care and Social Services Inspectorate Wales—Service Regulation and Inspection
Steve Dobson	Pennaeth Datblygu'r Gweithlu a Gofal Cymdeithasol yng Nghymru, y Bwrdd Cyfiawnder Ieuenctid dros Loegr a Chymru Head of Wales Workforce Development and Social Care, Youth Justice Board for England and Wales
Imelda Richardson	Prif Arolygydd, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru Chief Inspector, Care and Social Services Inspectorate Wales
Greta Thomas	Cyfarwyddwr, NSPCC Cymru Director, NSPCC Cymru/Wales
Keith Towler	Comisiynydd Plant Cymru Children's Commissioner for Wales
Sue Williams	Pennaeth y Bwrdd Cyfiawnder Ieuenctid yng Nghymru Head of the Youth Justice Board in Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk
Siân Thomas	Gwasanaeth Ymchwil yr Aelodau Members' Research Service

Dechreuodd y cyfarfod am 12.49 p.m.
The meeting began at 12.49 p.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good afternoon, everyone. I welcome Members to today's meeting and I remind everybody, members of the public and Members, that headsets are available to hear the simultaneous translation and to amplify the audio. If anyone has any problems using these, the ushers can help. Committee members and members of the public may wish to note that the simultaneous translation feed is available on channel 1, while channel 0 is the feed for the language being spoken.

[2] I would be grateful if everyone, Members and members of the public, could ensure that mobile phones, BlackBerrys and pagers are switched off so that they do not interfere with the broadcasting and other equipment. I remind everybody, including our witnesses today, that the microphones are operated remotely and so you do not have to press any buttons.

[3] If it becomes necessary to evacuate the room or the public gallery in the event of an emergency, everyone should follow the instructions of the ushers, who will be able to guide you to an appropriate exit.

[4] We have received apologies from Ann Jones for today's meeting, and I know that Dai Lloyd will be arriving later. Some Members have indicated that they have to leave early. With those exceptions, are there any other apologies for absence? I see that there are not, so I invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none.

12.51 p.m.

Ymchwiliad y Pwyllgor i Fyrddau Lleol Diogelu Plant yng Nghymru: Tystiolaeth gan yr NSPCC
Committee Inquiry into Local Safeguarding Children Boards: Evidence from NSPCC

[5] **Darren Millar:** I am delighted to welcome Greta Thomas, director of NSPCC Cymru. If you are content, we will go straight into questions. We have received a copy of your paper, for which we are very grateful and which has been circulated.

[6] **Ms Thomas:** Absolutely, that is fine. Thank you very much for the opportunity to be here.

[7] **Darren Millar:** We are delighted to have you. In your written evidence, you talk a lot about the progress made in implementing the recommendations of the Welsh Government's local safeguarding children boards task group report. You made lots of references to that and you said that you were disappointed that you did not think that that had been followed up sufficiently. What aspects of that report in particular and which recommendations are you concerned about?

[8] **Ms Thomas:** I have it in front of me now, actually. These are key things that we refer to as we go on in our written evidence. Specifically, the funding issue formed very much a part of the recommendations. In addition, we refer to the recommendation that guidance be developed to cover the role of partnership bodies, and the recommendation that the Assembly Government consult on further guidance on the scope and responsibilities of LSCBs and other

partnerships. They are themes that we expand upon, but they were already in the report that was published in 2008, and I think that there is also a reference in the recommendations to the link with vulnerable groups, sexual exploitation, and child trafficking. So, those are the things that we particularly wanted to highlight.

[9] **Darren Millar:** This inquiry gives us the opportunity to highlight those and to have a look at that previous report and see whether there is anything else that we want to tease out. We have a number of questions on it.

[10] **Lorraine Barrett:** In your written evidence, you recommend that the committee should examine not only the policy and guidance relating to the safeguarding children boards, but also the legislative framework, to ensure that any key recommendations that need a legislative basis are considered. Can you expand a little on your thinking in that regard?

[11] **Ms Thomas:** We thought that the original guidance took a general overview of the safeguarding of all children and young people. Now, the new legislative competence Order gives the Assembly considerable primary legislative powers that could perhaps be used to tighten up some of the safeguarding arrangements in Wales. We feel that if that guidance had been around originally, when we were looking at the guidance for LSCBs, we could have been more prescriptive.

[12] One area that you could look at—and there are references to this in other parts of the submission—is the terminology and the interpretation of child protection and safeguarding. I think that we would have had the opportunity to look at that. We are not giving all the answers here; we are just saying, 'Look, there are these powers here and we would really like to see a committee or a group looking back—not changing it, but looking at how it can be tightened up'.

[13] **Lorraine Barrett:** Could you let us have a note afterwards, with some specific examples of which areas you think need to be looked at, rather than just saying, 'We need the legislation just in case'? Could you give us some meat on the bones?

[14] **Ms Thomas:** Okay.

[15] **Darren Millar:** Yes, that would be helpful.

[16] **Ms Thomas:** If there are things that you would wish us to go away and come back with, we would be happy to give you more written advice following this session today.

[17] **Darren Millar:** Thank you for that.

[18] **Peter Black:** In your written evidence, you recommend that the Welsh Government provide further clarity over how the newly reorganised national health service structures will meet their statutory duties. You go on to say

[19] 'that the re-organisation is also used as an opportunity to review how best to support health input into LSCBs'.

[20] Do you have any evidence to date that the NHS reorganisation is having a negative impact on the work of local safeguarding children boards? If so, can you give us some examples?

[21] **Ms Thomas:** Our experience of health professionals' input to LSCBs has been that we have some of the most hard-working professional colleagues around, but we are very conscious of how overworked some of them are. Designated doctors and nurses are covering

five or six LSCBs. So, we are concerned about that.

[22] The biggest concern that we had when we looked at the guidance on the reorganisation was that there was absolutely no mention of safeguarding children in it, and so our response highlighted that as a criticism. We were very pleased that the Minister's response was to set up a review group chaired by Sir Mansel Aylward, and we have already met with Sir Mansel Aylward to look at some of the specifics.

[23] So, coming to your question, one issue is that general practitioners' input to LSCBs or to child protection case conferences is very minimal. It is very difficult to get that representation. So, quite apart from the case load, We felt concerned about the dumbing down of the designated doctors' and nurses' roles by the lack of reference to them in that report. We were, to some extent, reassured when we were told that they were there but that that had not been spelled out. It needs to be spelled out because, unless you spell out the exact role of health professionals, the lines of accountability and the resourcing, you will be muddying the waters. So, we are working on that. As I said, I have already met with Sir Mansel, we have gone away, and we are prepared to have more input as that review group develops its work.

[24] **Helen Mary Jones:** The question is specifically about the impact of the new bodies, but does the NSPCC have a take on the history of the involvement of the health service in local safeguarding children boards, particularly on any issues with sharing information and whether the people who were attending were senior enough to make decisions about that sort of thing? Following on from Peter's question, my perception is that the new situation might make the situation with health engagement worse but, based on anecdotal evidence, I am not sure that it was brilliant before. I am not sure whether you, as an organisation, have a take on that.

[25] **Ms Thomas:** Moving away from the designated doctors and nurses whom I have already referred to, one of our concerns with health input relates to adult services. As has been highlighted in several serious case reviews, the lack of communication between adult mental health services and children's services has meant that safeguarding issues and child protection issues have been missed. So, one concern of ours over the years—and it goes back a long time to the area child protection committees—has always been with adult mental health services, particularly where there are concerns about a parent or carer and there are young children in the house.

1.00 p.m.

[26] Sadly, we have dealt with cases where parents have committed suicide and taken the children with them. So, it is really important to have a close liaison with those professions, and input to the LSCBs is a very important strategic starting point.

[27] **Darren Millar:** Thank you for that. It is very important that we take note of that.

[28] **Val Lloyd:** Staying with the topic that Peter mentioned and specifically regarding the voluntary sector, you tell us in your evidence that the task of engaging the voluntary sector should not be underestimated but that in your experience, this has worked well when the representative has been from the local voluntary sector council. Given your concerns about the size of the task, are any other measures needed to support the engagement of the voluntary sector in LSCBs?

[29] **Ms Thomas:** Certainly, and I think that there has been confusion between representation and participation. I would certainly say that, even with an organisation such as ours, the NSPCC, we are there representing our own organisation. We cannot represent the voluntary sector, because we do not have the infrastructure to cascade information down,

which is why it works well when you have someone from the voluntary sector council present.

[30] The importance of having a representative from the voluntary sector council present is that the voluntary sector council will be able to reach all those smaller groups, which are the ones sometimes working with some of the most vulnerable groups, which are groups that social services and the health service sometimes find it difficult to reach in our communities—groups without the necessary infrastructure. Voluntary sector councils can reach those groups, so it is really important for us to look at the training and the input that voluntary sector councils have to enable them to be able to cascade information and not only share information but look at how they involve those groups in training on safeguarding and child protection. Certainly, NSPCC has been involved in cascading information and training through the voluntary sector on occasion across Wales, but that needs to happen in a much more systematic way.

[31] **Andrew R.T. Davies:** I would like to touch on partnerships, because in a lot of these organisations bringing everyone together is quite a challenging experience, to say the least. The recent Care and Social Services Inspectorate Wales report highlighted the key fundamentals and confusions around some of the responsibilities and boundaries that different organisations have. You have a great deal of experience in working with all of these organisations. What would you say would need to be addressed specifically to try to break down this confusion and ensure that continuity of working together?

[32] **Ms Thomas:** First, I will look at the organisations and then the different partnership groups. Taking the organisations first, we need to be absolutely clear that although the legislation says that every organisation has to be responsible for safeguarding, our experience is that very often that does tend to be shifted to social services. So, we believe that there needs to be much more emphasis right across the board about the safeguarding responsibilities of the organisations that are represented at LSCBs and those that are not. So, we need to look at communication and we need to look at training.

[33] We also need to look at auditing in terms of how that is carried out. I know that some local children safeguarding boards undertake audits of how organisations are fulfilling their safeguarding responsibilities. I am not aware of any of the 12 LSCBs that the NSPCC is on undertaking that work. When I have seen it done, it is very comprehensive and it highlights gaps in practice and knowledge around safeguarding that the LSCB can then look at in terms of training plans.

[34] **Andrew R.T. Davies:** Why would auditing not be undertaken? It seems to be a relatively simple mechanism for trying to understand a problem. If you do not audit, how can you hope to solve the problem? Why is that not being done? Is there a lack of will to do it or lack of resource to do it?

[35] **Ms Thomas:** What we are talking about is a consistent audit that maybe the LSCB would carry out, because some of the organisations will carry out their own audits. It is about having a consistent audit across the board. It can be quite time consuming and detailed. It may well be down to resources, because, again, we have talked about the funding and the resources that are available to LSCBs. Where you have a business manager in place to drive things such as this forward, it is often much easier for those things to take place.

[36] The other part of your question was around the confusion, perhaps, between different partnership groups. That is an issue that has concerned us, because the LSCBs have responsibility for safeguarding and child protection but, quite rightly, the Assembly Government has been quite clear that they must focus on the child protection element first and foremost rather than trying to move out into the wider coverage. However, it has not been

prescriptive, so what we find is that some LSCBs focus very tightly on the child protection element of their responsibilities and some of the other wider safeguarding responsibilities are undertaken by the children and young people partnership groups and the community safety groups.

[37] In fact, some of the safeguarding elements are sometimes undertaken by the community safety groups—for example, in relation to domestic abuse—and there is not always very clear reporting between the LSCB and the children and young people partnership group on how those safeguarding elements of the work are being undertaken. So, we would like to see that being very prescriptive, so there is real clarity around reporting back on how those safeguarding activities are being carried out.

[38] You have the 22 local authorities, and you have discretion around where some of these tasks are held. For organisations that span more than one local authority, of course, you also have those differences to contend with, you have to ask: is this sitting with the children and young people partnership or, in this particular area, is the LSCB carrying out these responsibilities? So, although the whole principle of looking at local need and discretion is a good one, when you are talking about consistency in terms of safety it has not, in our experience, worked out terribly well.

[39] **Irene James:** Good afternoon. My question is on funding. In your written evidence, you recommend that

[40] 'the Assembly Government consults on a broad formula for contributions from statutory board members, based on percentage contribution, and monitors the application of this formula, with a view to strengthening legislation and guidance if necessary.'

[41] Do you think that it is feasible for the Welsh Government to issue a statutory funding formula given the non-devolved nature of some of the key statutory partners, such as the police and the probation service? How do you think that such a challenge could be overcome?

[42] **Ms Thomas:** Just before I move into the answer, I will say that one of the greatest frustrations that I have around this is that after 25 years of working in child protection and safeguarding, having previously being on area review groups, area child protection committees, and now being on LSCBs, we do not have a formula. When I think of the hours and of all that professional resource spent discussing and debating funding contributions at different LSCBs, it is heartbreaking. The discussion just goes round in circles. So, 25 years on, we still do not have this formula.

1.10 p.m.

[43] I would hope that if the Assembly took a lead that would be a starting point in producing that formula. I know that a number of LSCBs in England have introduced a formula and have co-operation from probation and different organisations. I take your point; it is not easy, because it is about co-operation, but a strong lead is important.

[44] **Darren Millar:** We heard evidence a fortnight ago from, I think, the police, which referred to a funding formula that operates in Anglesey. Are you aware of that funding formula and would you be able to support that funding formula as a basis on which to work?

[45] **Ms Thomas:** I am not aware of it, but one of my colleagues is represented on the Anglesey and Gwynedd group, so I will come back to you on that one.

[46] **Darren Millar:** If all the partners consider it to be fair, then it might be the basis for a formula across Wales. Sorry about that interruption, Irene.

[47] **Irene James:** That is all right. My next question is about vulnerable groups. Within the remit of this inquiry, the committee is reviewing the effectiveness of the LSCBs in promoting the protection and welfare of specific groups of vulnerable children, such as children with disabilities, asylum seekers, trafficked children, and black and ethnic minority children. Does the NSPCC have any evidence of shortcomings in respect of the role that LSCBs play in protecting these groups of children?

[48] **Ms Thomas:** As we said in our written submission, we are concerned about the vulnerability of disabled children. We know that they are three to four times more likely to experience abuse, and we could be more proactive in taking that forward. We can look at some of the investigations that the NSPCC has been involved in. Until very recently, we ran a nationwide independent inquiry service and some of the work that we have been involved in has been investigating situations where there has been abuse of disabled children, sometimes in public settings. Our concern, in looking at what has happened in those examples, has been that there has not been sufficient input in terms of the LSCB in the guidance. I am sorry, I am being cautious in choosing my words, because I do not want to breach confidentiality.

[49] So, the specific question would be around some of that highly confidential work that we have undertaken that we have then fed back to key professionals, and to LSCBs, about actions that need to be taken in terms of gaps. Those gaps tend to have been in training and knowledge. So, there is a gap in training and knowledge between the staff who are caring and responsible for working with parents and carers with disabled children and staff who are undertaking safeguarding. Safeguarding is everyone's responsibility and training and knowledge should be across the piece. We feel that by bringing disabled children into the mainstream of LSCB work, we would be more proactive in addressing that.

[50] **Darren Millar:** I think that you have answered the next question there, so we will move on to information sharing. You touched on this a little earlier in one of your responses, but perhaps we can tease some more information out from you. You mention in your written evidence the issue of information sharing, particularly where there have been deaths of children over a number of years, and that you do not think that that has been addressed or tackled properly. The Wrexham Local Safeguarding Children Board told us that the harmonisation of existing information protocols would be a useful approach. What is your view on this?

[51] **Ms Thomas:** I think that, again, that we should see more robust monitoring and follow-up of actions and recommendations from serious case reviews. Time and again, you read a serious case review and its recommendations are the same as those of other reviews. There are some very good examples, where some of the LSCBs have been very good at holding to account the agency members on reporting back on action plans, because the action plans are around each agency from the LSCB taking that information back, cascading it, and making changes, whether they are about training or about ensuring that information streams within their organisation are effective, and we find that that does not always happen.

[52] **Darren Millar:** To what extent do you think that the delay between a serious incident and the report being produced causes a problem with implementing change? Do you think that it does cause a problem?

[53] **Ms Thomas:** Quite frankly, very often, once you start to look at recommendations—we are involved in authoring a lot of serious case reviews in Wales—you see that organisations have already started to implement actions. There are often good reasons for a delay in the production of a serious case review, but, quite rightly, you cannot wait to take action. Each individual agency has to do its own internal management report and that is the crucial element. That needs to happen very early on. You know from that internal

management review that if there are issues that need to be addressed then the action needs to be taken very early on.

[54] So, by and large, there will be some, more strategic, recommendations that cannot be pulled together until the end but, generally speaking, where there are individual agency errors and individual agency responsibility, they should be picked up at an early stage. Quite frankly, with regard to serious case reviews, in the last three to four years that I have rarely seen anything new in terms of learning coming out of a serious case review.

[55] **Darren Millar:** Why do you think, then, that those lessons are not being learned? On the one hand, you say that very often the process of implementation starts well before the publication of a report, but, on the other, you say that people are not implementing the recommendations because the same problems crop up every time. So, where is it going wrong?

[56] **Ms Thomas:** It is about looking at the structures and communication. Fundamentally, it is about the responsibilities of each individual organisation in terms of its safeguarding responsibility. It is absolutely about the training, supervision and the knowledge and having the resources and being robust enough to train staff and then to monitor and audit the case load. High case load is another issue. High case loads and supervision are issues, because if you are supervising effectively, and have effective support and supervision mechanisms in place, whichever statutory or voluntary organisation is involved, you should be picking up the issues as they come up or you should be picking up patterns of concern and addressing them. Case load supervision is a theme that also comes up. So, for me, it is about case load supervision and then effective communication between the two organisations.

1.20 p.m.

[57] There is another key issue as well, and that is to do with the interpretation of child protection and safeguarding thresholds and not having a consistent understanding that staff are confident in using. You may find that thresholds for child protection differ across local authorities, and that can be very confusing, particularly for staff at the grass-roots level, namely the staff who are working with the vulnerable children and families. If those staff are confused about where the thresholds for child protection lie, then you have a problem. So, one of the key things that I would really like to see in terms of LSCBs would be multi-agency training, absolutely, and something that is very clear and easy for people to understand in terms of what the threshold is, when to make a referral, and whether it is easy for to make a referral.

[58] We in the NSPCC audit case load and, periodically, I dip into it, and I have picked up concerns about the times when staff have found it a real battle to make a referral. Now, our expectation would be for staff to refer that up to a manager, after which we have a responsibility to deal with the individual case and also to raise the issue with the LSCB. Organisations need to have the confidence to do that.

[59] **Darren Millar:** Okay, thank you. Andrew R.T. Davies is next.

[60] **Andrew R.T. Davies:** Thank you very much for your paper; I forgot to thank you for it when I asked my first question. It is very informative. You raise the issue in your paper of shadow boards for local safeguarding children boards and, in particular, young people's involvement. I think that you highlight two examples: Merthyr and Caerphilly. Could you give the committee a taste of why you believe this to be such a successful innovation and, in particular, how you would like to see it wound out to other areas so that there is that engagement, and that challenge, shall we say?

[61] **Ms Thomas:** It is still early days for those authorities, and they are two very different models for involving children and young people. We need to look at the merits of both models to see what the quality is. The worst possible thing is to pay lip service to what children and young people are saying, so you have to have a look at what the LSCB wants from young people's involvement. Caerphilly has done a very good job in engaging young people in that debate and in looking at what safeguarding means for them and what actions they would like.

[62] **Andrew R.T. Davies:** It is about having focus days rather more than a full-blown shadow board?

[63] **Ms Thomas:** Yes. Forgive me, but I do not know about the Merthyr board in as much detail—I would add that rider. In the Caerphilly example, I think that they are holding a focus day and using skilled staff. It is very difficult, and we have struggled ourselves. You can bring a group of young people together, but you have to do a lot of preparation for them to be confident and freed up to be a representative group, because you do not want just the very articulate young people; you are trying to reach out and get feedback and input from young people who may be in some of the most vulnerable groups. It can be very difficult to involve them on a shadow board. One way of doing it is to have a focus day that can perhaps be broken down so that you work with different groups and use different methods of involving the young people.

[64] I would highlight the fact that the NSPCC is to hold a conference that will pull together aspects of what has been done in terms of young people's participation and input to LSCBs across England. I can let you have the report from that event when it happens.

[65] **Andrew R.T. Davies:** What timeline are you working to for that?

[66] **Ms Thomas:** That is happening in June. So, there will be lots of examples there, and I think that it is about looking at—

[67] **Andrew R.T. Davies:** What you are telling us is that there is no one set model, and that it would be for the local safeguarding children board to determine its approach, but that the overriding principle should be that young people should have a role to feed into the processes.

[68] **Ms Thomas:** Absolutely. We have to be wary in doing that by thinking, 'Why are we doing it? What outcome are we looking for here?'. It cannot just be about a feel-good factor. We have to ask whether we are enabling these young people to feel that they are having a significant input. If the group operates in a skilful way, it can be very empowering for the young people, but there is no one way of doing it.

[69] **Darren Millar:** That just about brings us to the end of questions. The clock has beaten us, unfortunately. Thank you for the evidence that you have provided, written and oral. We look forward to receiving the further information.

[70] **Ms Thomas:** Thank you very much for this opportunity and good luck on your deliberations.

1.26 p.m.

Ymchwiliad y Pwyllgor i Fyrddau Lleol Diogelu Plant yng Nghymru: Tystiolaeth gan Gomisiynydd Plant Cymru
Committee Inquiry into Local Safeguarding Children Boards: Evidence from the Children's Commissioner for Wales

[71] **Darren Millar:** We will move straight into item 3, continuing with this inquiry. I am delighted to welcome Keith Towler, the Children's Commissioner for Wales, once again to our committee. Thank you for coming. If you are content, we will go straight into questions. We have all received a copy of your paper, which we are very grateful for. I will kick off.

[72] The evidence that you have provided us has been pretty consistent with some of the evidence we have received from other witnesses, in particular the NSPCC. You have made reference to the local safeguarding children board task group set up by the Welsh Government. There have been some concerns that some of the recommendations from that report have not yet been implemented. Can you share some of those concerns with us? Which particular recommendations are you concerned about?

[73] **Mr Towler:** Thank you for the opportunity to be here, before I go straight into my answer. My overall message to you as a committee today is that we need to inject some pace and momentum into what we are trying to do around safeguarding and child protection. I find it quite disappointing, but understandable, that the recommendations for action in the report that we had following a review in 2007 were overtaken by Haringey and how we wanted to respond to what had happened. Nevertheless, themes in that report no doubt echo many of the themes that you have heard in your committee inquiry and echo what people are saying in the field. There is an issue for me as the children's commissioner about how I monitor developments and how I hold people to account. There is a role for your inquiry and whatever recommendations you come to about the role that you will have in holding people to account. In the themes of that review and in the work of the Wales safeguarding forum, which the Deputy Minister has now put in place and which I am very pleased about, there is an opportunity for the safeguarding forum to pick up those recommendations. After reports, inquiries, and recommendations, there has been very little action, and that is just a huge concern for me.

[74] I do not think that there is anything more important than safeguarding and child protection issues. I think that safeguarding is just the No. 1 priority for all public service agencies, so I do not think that it is good enough that we are in this position of reflecting on issues that colleagues will have reflected on as long ago as 2006 and 2007 and coming to the same conclusions but still seeing inaction.

[75] **Darren Millar:** Of course, the purpose of this inquiry, you will be delighted to know, is to inject some momentum into these particular issues and try to bring some action forward.

1.30 p.m.

[76] **Lorraine Barrett:** Following on from that theme, the findings of the Care and Social Services Inspectorate Wales report in 2009 said that

[77] 'There is… no clear relationship between the effectiveness of LSCBs and the quality of practice and services in safeguarding and protecting children.'

[78] What do you see as the implications of that finding for the original purpose of establishing the board and also for the future work of the board?

[79] **Mr Towler:** The CSSIW report is excellent. What a fantastic piece of work; it really

focuses on where some of the perceived failings appear to be. There is a sentence in that report that really struck me when I read it for the first time—I have read it a number of times. It states that

[80] 'too much reliance and expectation [is] placed on local authority social services.'

[81] When you think about the safeguarding agenda and the child protection agenda, if agencies that are involved with local safeguarding children boards are still saying, 'This is for children's services and nobody else', it is just not good enough. What the CSSIW did, and indeed the health inspectorate report that followed or was published quickly thereafter, was to put its finger on a number of the critical issues.

[82] Information sharing, for me, is one of the critical issues. I do not know how many serious case reviews I have read, but I have read a lot of them. I think that it erodes public confidence in what we are trying to achieve for children when you hear the same recommendations coming out of serious case reviews and you hear that information is not being shared. The strategic responsibility of local safeguarding children boards has to crack that absolutely. The fact that it is not doing that means that there is a disconnect between the strategic work of the LSCBs and what our front-line staff are doing every day. Let us be honest, we have a pretty demoralised, heavy-hearted, beaten-up front line in relation to children's services—that is social workers and others—and a massive amount of stress.

[83] For me, the work that the CSSIW did was important because it put a mirror up and said, 'There is a big disconnect in a number of ways'. If you just pick any one of the issues that were raised in that report—information sharing is the obvious one—it would illustrate a fundamental disconnect between the strategic and policy-level work that is going on in LSCBs and how we support front-line staff.

[84] **Lorraine Barrett:** Thank you. I think that there are a couple of recommendations there.

[85] **Darren Millar:** It is pretty consistent with the other evidence that we have received so far.

[86] **Peter Black:** You say that the terms 'safeguarding' and 'child protection' are frequently used and that they have almost become synonymous. You go on to say that we need accountability and definitions for safeguarding and child protection to be clearly outlined and understood by all agencies. Can you explain the basis for your concerns and outline the relevance of the work of local safeguarding children boards?

[87] **Mr Towler:** Yes, indeed. This came home to me particularly at the recent Welsh Local Government Association safeguarding summit, at which colleagues from a number of agencies, devolved and non-devolved, talked about safeguarding and child protection. A couple of people commented on how people interpret the words 'safeguarding' and 'child protection' and realised from the LSCBs that they are involved in that some agencies are talking at odds with each other when they talk about safeguarding and child protection. That is quite surprising, because within the all-Wales child protection procedures, there is a glossary of terms that it makes it very clear what safeguarding is and what the role of child protection is in relation to a safeguarding function. So, I think that we do not have to worry about the definitions so much; we need to make sure that people's understanding of it is clear. I do not think that it is as clear as it could be.

[88] I heard a director of education, Mark Provis, at that WLGA summit say, 'As director of education, my prime responsibility is safeguarding children, and then it is the education of children'. Now, that is such a refreshing thing to hear because it is absolutely right. In

working to ensure that children have optimum life chances, and education is a big part of that, his safeguarding responsibilities are very clear to him. The thresholds for triggering a child protection referral and concern about abuse and neglect are so open to interpretation that you see different thresholds operating across Wales, and we really need to sort that out. Does that help?

[89] **Peter Black:** Yes.

[90] **Darren Millar:** In terms of sorting it out, however, you say it is the understanding rather than the actual definition. How do we give people a proper understanding of what constitutes a child protection issue as opposed to a safeguarding issue?

[91] **Mr Towler:** My experience as the children's commissioner and the work of my investigation and advice team show that there is sometimes confusion about children in need and child protection issues, and there is an age dynamic to some of this. There is great reluctance at ages 15, 16 and 17 to progress a child protection referral in some local authority and LSCB areas. So, in the case of children of primary age and under being subject to a child protection referral, I would have some confidence that the child protection referral would be picked up. However, every now and again—this is not every day of the week—my officers will have to press on the issue of child protection referrals for teenagers, for 16 and 17-year-olds. Look at the issues that were raised in the three serious case reviews that were published recently in Swansea. The issues behind those serious case reviews illustrate the point.

[92] This is not a criticism of the front-line staff, because they are under a lot of pressure, but there is something about the management and supervision of those staff and the case loads that they are coping with, as well as the resilience of front-line child protection teams to cope with things like sickness levels and people going on good training courses and all the things that they need to develop their staff. We should be asking questions about front-line organisations' resilience in relation to child protection services. That puts the pressure on. When somebody like the children's commissioner comes to somebody and says, 'Look, I know this lad is 16, but I think that this is a child protection referral and I am going to put pressure on', to which they will say, 'Okay, I will go and do it', you can understand why they are resistant; it is because their case loads are enormous and they are having to prioritise the things that are coming in. Who would be a social worker making those decisions day in, day out? That is a tough place to be.

[93] **Darren Millar:** Absolutely.

[94] **Andrew R.T. Davies:** Thank you for your evidence. Before I ask my main question, I want to take you back to the point about information sharing that you highlighted earlier. Most people would say that that is not rocket science, but since I have been speaking for health for the Conservatives, I cannot count the number of times we have heard of problems that have arisen because no-one shared information because it was sat on someone's desk instead of being sent to someone else. You talk of cracking that nut. Could you give us a taste of your view for cracking the nut? It is not the case that we do not have the information. If you are trying to solve a crime for which you do not have any evidence, then it is quite difficult. It seems that we have the evidence but that it is not being shared around the interested parties.

[95] **Mr Towler:** Absolutely, we are awash with information. Lots of agencies have loads and loads of information. I sit on the safeguarding forum, because I said that I wanted to ensure that we have some pace and I wanted to see the work of the safeguarding forum. Part of the work of the safeguarding forum has been to set up a sub-group to report to the forum specifically on serious case reviews and guidance on serious case reviews.

[96] At the WLGA summit the other day, I was talking to colleagues from health about information sharing. They made a really valid point because, like you, I was saying, 'I do not understand why, if we have the legislation and the guidance, people are not sharing information'. Colleagues in health were being very open and honest and they were saying, 'Well, unless you absolutely pin this down in guidance and give us a clear performance indicator that we will be inspected on for when we should be sharing information, how we should be sharing it and who we should be sharing it with—that is, confidential information and other information—it will not happen'. That is one of the challenges that we need to pick up.

[97] So, when I say that we should nail it, we absolutely have to nail it, and that would give the CSSIW, the health inspectorate and others the opportunity to measure performance against a very clear expectation. We do not need to look at the legislation; the legislation is pretty clear.

1.40 p.m.

[98] **Darren Millar:** Lorraine, do you want to come in on this point?

[99] **Lorraine Barrett:** Just briefly, where do the police fit into the information-sharing issues that you have just talked about?

[100] **Mr Towler:** Four-square right in the middle. I am sure that others have spoken about the WLGA's safeguarding summit, but the police representative at that summit that day, representing the four chief constables, was making it very clear that even though they work in a non-devolved world, they very much wanted to get on board with the information sharing and would sign up to protocols. The willingness is there at a strategic level in Wales to make this happen. We just all need to be singing from the same hymn sheet as regards how we do it. I do not think that we can—

[101] **Andrew R.T. Davies:** The guidance and key performance indicators would be the drivers that you would use. As you said, the legislation is there, so it is not a case of having to revisit legislation.

[102] **Mr Towler:** No, it is not. We need something that defines what people need to do and how they will be inspected, managed and their performance measured against that. I find myself wanting to be very prescriptive about it because you absolutely have to get information sharing right. So, there is no room for discretion, and you have to absolutely clear when information should be shared, how it should be shared, where in the process it should be shared, and who you should share it with.

[103] **Andrew R.T. Davies:** So, to use a tabloid saying, 'Zero tolerance'.

[104] **Mr Towler:** Absolutely. We know that it erodes public confidence to hear about serious case reviews and to hear people say, 'We have learned the lessons now' about something that happened two years ago, but if they have learned the lessons why are we constantly repeating the lesson about information not being shared? Clearly, we are not learning the lessons, and I think that that erodes public confidence in what we are all trying to achieve. That is unfair on those parts of Wales that have excellent child protection systems—and it is not all doom and gloom by any stretch of the imagination. There is some really good practice out there, but I can understand why the public does not have confidence in what we are doing, as I think that we, collectively, present ourselves as quite weak in relation to all this, and information sharing is critical to that.

[105] **Val Lloyd:** You said that the amount of people—[*Inaudible.*]—and you named the

police and the health service. Can you name the rest of the big ones? I think that I can guess them, but as we are saying—

[106] **Mr Towler:** For me, that is about local authority children's services and education authorities. They have to be included. I did not hear all of Greta's evidence from the NSPCC, but I think that the voluntary sector's role as members of LSCBs is important in this. I am sure that you will be looking at the membership of LSCBs and at the status of their members, but they should all be signed up to information-sharing protocols so that they understand their responsibilities, and that includes the voluntary sector as well as the statutory sector. I know that they have different functions, but we have to be absolutely clear about that.

[107] **Andrew R.T. Davies:** You highlighted in your recent report your concerns over the reorganisation of the NHS and the local health boards' ability to participate fully in the local safeguarding children boards. Are your concerns being borne out now—and I appreciate that it is still relatively early days, but we have had seven or eight months since the reorganisation—or are things bedding down quite nicely, thank you, although you still have a watching brief?

[108] **Mr Towler:** I had an immediate concern about the reorganisation of the health service, because I could not see the words 'children', 'children's services' or 'child protection' featuring very highly. I hear what people in the health service are saying, which is that 22 LSCBs are difficult to cover, and that they cannot always get the people there whom they need to get to those meetings, and I am hearing very positive messages from health professionals about engaging in the safeguarding and child protection agenda. It is too early for me to judge whether the concerns that I was registering a few months ago are being addressed, but I know that they have been heard, which I am pleased about.

[109] **Andrew R.T. Davies:** So, the marker is down, but the jury is out.

[110] **Mr Towler:** Yes, absolutely.

[111] **Irene James:** Moving on to vulnerable groups, within the remit of this inquiry, the committee is reviewing the effectiveness of LSCBs in promoting the protection and welfare of specific groups of vulnerable children, such as trafficked children, disabled, black and ethnic minorities and asylum-seeking children. Do you have any evidence of shortcomings in respect of the role that the LSCBs play in protecting such groups of children?

[112] **Mr Towler:** It is part of what I was trying to describe earlier, namely the disconnection between the policy and strategic responsibilities of the LSCB and the front-line staff of its member organisations and agencies. Some front-line staff do not really register what the LSCB is. That is not a criticism of them, as no-one has really spoken to them about it or made it understood. My office published 'Bordering on Concern', looking at child trafficking in Wales, and we discovered some children who had definitely been trafficked into Wales from other countries in the UK as well as from overseas, and yet levels of awareness among practitioners and LSCBs about trafficked children was quite low.

[113] LSCBs have strategic responsibilities to develop their staff and to make them aware of issues in relation to disabled children, trafficked children, or children seeking asylum at that kind of strategic level, but the experience of front-line staff in getting information, training and development in relation to those does not appear to me to be happening as it should be. That comes back to the point about resilience because, at the front line, we do not have the capacity to respond as we would want to. So, I think that we need to unpick the responsibilities of the LSCBs.

[114] What the LSCBs have to be concerned with more than anything else, it seems to me,

is how they will support the practice and delivery of services to vulnerable children. It has to be about a practice agenda, and I really do not yet see that happening as I would like to see it happening.

[115] **Irene James:** So, you do not see it happening at the moment, but do you have any idea of how it should move forward so that it does happen?

[116] **Mr Towler:** I would like to see LSCBs being very clear about their staff training and development plans over the next few years. I would like to see them really grasping the issues with pooled budgets and pooled training, so that you have multidisciplinary teams from social services, education and the police all training together and developing a common understanding. I would have thought that an LSCB should be producing those kinds of training and development plans for staff, and I would also like to see that happening for team managers, with help on casework management, supervision and support. The isolation of staff, particularly on child protection, is unacceptable, and it is a role of the LSCB to make sure that managers understand their responsibilities. If you are managing a team of staff, and you are seeing your staff monthly—and I have been in this position—you are the one person who can see the patterns that your team is working on, so you have a responsibility as a team manager. Sometimes, we promote people into team manager jobs because they are great practitioners, but the management function is actually a different skill.

[117] So, what do the skills and experiences of our managers look like? Are they equipped to do the job? What specific training and development do they need? Those are the issues that LSCBs really need to be honing in on, and we need to see that happening on a multidisciplinary basis.

[118] **Peter Black:** May I just come in on that? The local safeguarding children boards are, effectively, a partnership. They do not employ staff directly, so they do not employ managers. They take a strategic overview and try to bring people together. What you are describing there is quite a massive expansion of their roles, which would require proper financing. Do you think that that sort of expansion is necessary, or could that be done by local service boards or by other partnerships?

[119] **Mr Towler:** I get a sense that, out in the field, there is a willingness to think creatively about the role that LSCBs play. They just need some kind of licence from the centre to encourage them to think creatively about how they do this and how they can work together.

1.50 p.m.

[120] My sense, certainly at senior levels among those agencies, is that there is a willingness to do this, but for them to have the confidence to do it requires them to have something centrally that actively encourages them to work in that way. I think that if you were to speak to practitioners about training and development issues and you broached the idea with them that social workers might go and do training with police officers, health professionals and teachers, they would bite your hand off for the opportunity, because they would love to be doing that kind of thing. So, I think that the opportunity is there and I think that the willingness to do it is also there.

[121] **David Lloyd:** There is a part of your paper that talks about dissemination of information from local safeguarding children boards out there to practitioners on the ground. You say that

[122] ‘concerns have been raised that GPs have difficulties engaging with LSCBs’

[123] and that

[124] ‘these messages are not always conveyed to individual professionals in a timely fashion.’

[125] Can you elaborate on why there are delays and why there are difficulties in disseminating information from the LSCBs downwards?

[126] **Mr Towler:** I suppose that it is most obviously felt for me in the serious case review process. When LSCBs are taking things forward and thinking about the ways in which lessons can be learned, information can be shared and practice can be developed, with the best will in the world you are not going to get all your GPs or all your social workers in one room at the time, so you need to be quite creative about how you work at this.

[127] Again, something that I know colleagues in the inspectorates are thinking about is the role and function of an LSCB in ensuring that everybody in its patch understands the critical learning, whether that be something around best practice that people ought to know because it might help inform their own practice, or something that we need to do better. It seems to me that we really are not engaging on that.

[128] In part, that is about the status of the chair of the LSCB, because the chair of the LSCB, in my experience, is predominantly the director of children’s services. So, if as the chair of the LSCB I want to come and speak to the health service and to talk to GPs, I need the health service to recognise my status as the chair of the LSCB. It is not that the director of children’s services from the local authority is coming to speak about the matter—and so you get defensive—but the chair of the LSCB, of which you are a full and participating member. I think that the status of the chair of LSCBs is really quite weak, because the responsibility of the chair is to say, ‘This information needs to be shared. I want you all after this meeting to go back and do that’, but if you are the health representative and I, as chair, ask you how you have done that, if you do not want to play ball with me you do not have to, frankly. If my status as the chair of the LSCB is recognised, and as chair I hold you to account for not doing it, I think that sharpens things up. We really need to do something about that.

[129] **Darren Millar:** Irene, you have a question about the chair, do you not?

[130] **Irene James:** I do, and part of it you have already answered, because you say that ideally, in your view, the chair should be independent. You obviously feel this is quite important, but do you think that the Welsh Government should issue statutory guidance to that effect?

[131] **Mr Towler:** I said that in the ideal world, yes, the chair should be independent. Then I started to think, ‘Well, who are these wonderful people who will materialise to do this?’ [*Laughter.*] So, that is why I said it was in an ‘ideal world’.

[132] I think that the role of the LSCB chair ought to be about holding people to account, and asking, ‘How did you do this? Have you done it? Let me know that you have done it. I have said I want this done in three months, has it been done?’ If it has not been done, all the agencies that are part of the LSCB should recognise the role of the chair in holding them to account. It seems to me that that is critical.

[133] **Darren Millar:** Do you think that there is a risk that if that person is from one of the member bodies of the LSCB then he or she may not give that member body as hard a time as the others?

[134] **Mr Towler:** Absolutely. I think that it was the *Western Mail*, which I do not always

look to for—

[135] **David Lloyd:** Inspiration? [*Laughter.*]

[136] **Mr Towler:** Inspiration, yes. However, every now and again it puts its finger on the matter. When the serious case reviews were published in Swansea, in its editorial it produced a comment about the lead director of children's services, who was the chair of the LSCB and was publishing serious case reviews. It was not calling into question the integrity or the professionalism of that individual, but it said, 'This looks like you are looking at yourself. That role makes it look as if you are looking at yourself, so how robust are you really?' It comes back to public confidence. To what extent can the public have confidence that you as a director of children's services and the LSCB chair are saying, 'Look, it is okay, trust us, we have sorted this'? That is not having a go at anybody's integrity or professionalism, but it does not quite match up, does it? It seems to me that in that holding to account and that kind of management, the roles of the LSCB chair and the business co-ordinators or business managers that some LSCBs have is pretty critical.

[137] I think that the Welsh Government needs to issue some guidance around the role of the business co-ordinator or the business manager, the relationship to the chair, the authority of the chair as an LSCB chair, and what those representative agencies need to recognise. I think, too, that the LSCB chair has to be a member of the children and young people partnership, has to have some relationship with the local strategic board, and has to have an overview of what the other partnership arrangements are doing. That is a big job. That is a lot of work. To do that effectively and right and to ensure that lessons are shared and that things are moved forward is a significant chunk of work. In the ideal world, the chair would be somebody independent. We need to do some work on that, because these are significant roles in relation to safeguarding and protecting children.

[138] **Darren Millar:** It sounds like a full-time job as well.

[139] **Mr Towler:** In terms of the responsibility, can you think of a bigger one? It is massive, I think.

[140] **Darren Millar:** Peter, do you want to come in on this?

[141] **Peter Black:** The other issue that arose from that *Western Mail* spread was—

[142] **Mr Towler:** You will have read it, of course.

[143] **Peter Black:** I was at the meeting afterwards. [*Laughter.*] The other issue that arose was about the serious case reviews themselves and the ownership of those reports. The *Western Mail* had some leaked copies of previous summaries and compared them with the published summary. However, at the end of the day, all that is published is the summary itself. The report remains in the ownership of the board itself and there does not appear to be any scrutiny or transparency with regard to how accurate those summaries are. There is no reason to doubt their accuracy, but there is no transparency there. Is there any way that that can be overcome? I think that there are issues about publishing the whole report, but are there any ways in which that can be overcome and the level of transparency and accountability improved?

[144] **Mr Towler:** Clearly, local safeguarding boards—and, again, the role of the chair is important here—would have to take a view on whether the whole of a serious case review report could be published. There would be big issues in terms of confidentiality and there would be information that could not possibly be put in the public domain for very good reason. I do think, though, that—and this is nearly always highlighted with serious case

reviews—with the perceived delays that we have, with two or three years for a serious case review to be published, sometimes the public or people close to the case have an expectation of what a serious case review is that bears no relation to what it will do and deliver. So, by the time it is published it will automatically let people down because their expectation is—and I have spoken to members of the public about this—that this report will identify who is to blame, who will lose their job, and what exactly happened. Of course, a serious case review will not do a criminal investigation in the way that the public expects.

[145] So, one of the things that local safeguarding children boards need to get their heads around in terms of transparency is thinking very clearly about how they communicate, ensuring that they are not setting up a level of expectation about what a process is and what it will deliver, and being very clear at the outset about the timescales. If, for very good reason, things are being delayed or there is an element of work that had not been anticipated, which sometimes happens, stakeholders—in other words, the people closest to the case—should get updates about what is happening and why it is happening.

2.00 p.m.

[146] None of us should be hearing of situations where the first time that a parent, a relative or someone close to a child involved in a serious case review hears about its publication is at the point of publication or when they read about it in the *Western Mail* or *Daily Post*. As the key stakeholder, they should know what is going on. I think that we do not do that as well as we could.

[147] **David Lloyd:** I have a question about the Welsh children's safeguarding forum, which you mentioned earlier and which you are a member of. Could you outline how the work of the forum is relevant to local safeguarding children boards and tell us about any progress to date?

[148] **Mr Towler:** It is early days, but I think that a lot of expectation is being placed on the safeguarding forum. I welcomed the Deputy Minister's move in that direction. I think that Gwenda Thomas was right to set up the safeguarding forum and to say that it needed to be at a senior level. I do think that it needs an independent chair. I spoke to the Deputy Minister about that the other day and I know that she is actively looking at it. I sit on the safeguarding forum as an observer because I made a bit of a song and dance about it, saying, 'I want to make sure that we have some pace and some movement on this and I am going to take an active interest'.

[149] The terms of reference and the scope for what the forum is going to do look good to me. We very quickly said that we needed to do some work on serious case reviews and, while we did not need guidance to be rewritten everywhere else, in relation to serious case reviews I think that everybody on the forum was saying, 'We have to do something about serious case reviews'. So, we have a sub-group that is actively looking at serious case reviews and will report to the forum.

[150] So, I am reassured that that is happening. I am reassured that the Welsh Government is clear that we need to do something. I will repeat what I said right at the beginning, really, which is that this about the pace. The challenge for us as a safeguarding forum is to make sure that there are pace and momentum. Your inquiry is really important in that. It is not for me to say what you might want to do in the future, but one of the things that you might want to be very clear about, if you are making recommendations, is how you will monitor your own concerns. I can certainly do that as the children's commissioner and I think that that is an issue for you. The safeguarding forum is our major tool to make sure that this happens with the Welsh Government actively supporting and driving that forward. So, that is all good, but we need it to work at a real pace.

[151] **Val Lloyd:** In your written evidence, you outlined a range of issues relating to the effectiveness of the LSCBs and you have also done the same thing orally, of course. In your view, is there a priority issue or recommendation for action that you would like to highlight to us today?

[152] **Mr Towler:** A priority issue? I gave a bit of thought to this, so I have a list of things that I have written down. [*Laughter.*] Well, if it is a $64,000 question you can have 64,000 priorities.

[153] One of the things that I have not covered, but which I would want to mention, is the voice of children and young people in all of this. There are some great junior LSCBs. I have met young people in Merthyr and in Powys, and I know that there are others, too, that are actively interested in health and wellbeing and safety issues in relation to children. Again, in thinking about the role of the LSCBs and the voice of children and young people in decisions that affect their lives, the work of junior LSCBs and the adult LSCBs needs to be brought together so that adult members really begin to hear and understand what children and young people are saying about that experience.

[154] In terms of priorities, I have outlined a few. The absolute one is that LSCBs need to be focused on staff development issues in relation to training so that what they are driving forward is a practice agenda that will improve outcomes for children and young people. That, critically, is it. The work on serious case reviews needs to be given some oomph. I have already mentioned the role of the LSCB chair, the membership and the business co-ordinator or manager. They need to be given priority because they are the critical functions. I hope that I have managed to demonstrate to you that it is a really significant job that we are asking this chair to take on board and we need to really crack that.

[155] **Darren Millar:** Okay. I think that brings us to the end of our questions to the children's commissioner. I thank Keith Towler for his attendance today and for the very important evidence that he has given us to consider as part of the inquiry.

[156] **Mr Towler:** Thank you.

2.05 p.m.

Ymchwiliad y Pwyllgor i Fyrddau Lleol Diogelu Plant yng Nghymru: Tystiolaeth gan Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Committee Inquiry into Local Safeguarding Children Boards: Evidence from the Care and Social Services Inspectorate Wales

[157] **Darren Millar:** We will move straight into item 4 and continue with our inquiry. I welcome Imelda Richardson, the chief inspector of the Care and Social Services Inspectorate Wales, and Jonathan Corbett, the assistant chief inspector, to present oral evidence today. You have provided a written paper, which Members have had an opportunity to look at. If I may, I will go straight into questions.

[158] We have heard a lot so far in our evidence about your report of October 2009, some of the concerns that you raised in that report and some of the recommendations that were in it. In that report, one of the findings was that there was no clear relationship between the effectiveness of LSCBs and the quality of practice and services to safeguard and protect children. What are the implications of that particular finding for the original purpose of establishing the LSCBs and also for the future work of those boards?

[159] **Ms Richardson:** Unfortunately, no, there was no direct relationship. Obviously, the real importance of that is that you are looking for absolute accountability at the highest level, so you are looking for high quality senior managers to take those roles. It is important to commit people who are able to take decisions, make resources available and make improvement work.

[160] The findings of the report were about the quality of the leadership and that, unfortunately, was the driver of the effectiveness, from the evidence that we have. That leadership was very individual and not something that was embedded in the organisations. It really is about bringing together sufficient senior management who will engage with one another and look beyond the boundaries of their own organisation at the LSCB as being an effective organisation in its entirety, because of the importance of the work.

[161] **Darren Millar:** Is there anything that you wanted to add, Mr Corbett?

[162] **Mr Corbett:** I think that you can see that another finding was that practitioners were often not aware of LSCBs or what their role was. We said that there was no clear relationship; we did not say there was no relationship at all. It is highly likely that where you have a more effective LSCB, you will have better services on the ground. However, where you do not have a good LSCB, it does not necessarily mean that you will not have some good services on the ground. Clearly, to get the two aligned is really important. The chances are that if you do not have a good LSCB, that is probably indicative of the fact that the agencies are not working together effectively to safeguard children.

[163] **Darren Millar:** Thank you for those opening remarks. Lorraine Barrett has the next questions.

[164] **Lorraine Barrett:** In its written evidence, the National Society for the Prevention of Cruelty to Children recommends that this committee should examine progress in implementing the recommendations of the Welsh Government local safeguarding children board task group report. It says that it is disappointing that some of these issues have not been addressed where clear recommendations were made by that task group. Do you have a view on the recommendations that were in that Welsh Government task group report?

[165] **Mr Corbett:** That report is a couple of years old now and I think that a lot has happened since then because we have had the Haringey case, for example, and a lot of work has gone on following on from that. So, there has been further work to address not all, but many of those recommendations.

2.10 p.m.

[166] I think that it is a fair comment to say that those recommendations were made and that no action plan was drawn up specifically to deal with those, but many of the recommendations in that report have been followed through in the programme of work around safeguarding, particularly following on from the Haringey case—not every single one, but most of them.

[167] **Lorraine Barrett:** I was going to ask you why you think that there is a delay in implementing the recommendations, but you have just said that most of them have been implemented. I am not sure that—

[168] **Mr Corbett:** What I was saying is that, on most of them, further work has been done; so it is being taken on. One has to ask, ‘What is the position now in relation to those recommendations? Has work happened and, if so, has that taken it on? Are there any that remain outstanding and, if so, what is the position on those?’

[169] **Lorraine Barrett:** Okay. I am not sure who that is for, Chair. Is it for us to ask the Minister?

[170] **Darren Millar:** You could always find an excuse for delaying the implementation of recommendations on the basis that there is another serious case review going on, for whatever reason, that could have a bearing. Is that a fair comment? If so, should the Welsh Government not just get on and deliver on these recommendations when it is presented with them?

[171] **Ms Richardson:** It is reasonable to take stock of these recommendations in line with other pieces of work that are also under way, in terms of serious case reviews, because there is obviously going to be an inter-relationship between those and how the LSCBs function. It is very important to have designated professionals attending the LSCB, but whether they all have to be statutorily responsible, I am not so sure. The best working relationships are about mutual understanding, mutual respect and engagement around the common task, and that could be achieved whether you were statutorily responsible for that work or had a statutory responsibility to be in attendance.

[172] So, on that particular point, you could play it either way. If it is a good, effectively run safeguarding board, you are going to have to work on the key elements that are about leading it and leading those members of the group to achieve what you are there for, which ultimately is the improvement of safeguarding within that community for children.

[173] **Peter Black:** Looking at roles and representation, a range of witnesses have raised concerns about the role and scope of LSCBs and how this overlaps with issues of membership and representation. For example, in its written evidence, Wales Probation Trust state that it questions the wisdom of having LSCBs in each local authority, most doing very similar work. What is your view on that?

[174] **Mr Corbett:** Again, if you look at our report you will see that a couple of LSCBs have already merged—Anglesey and Gwynedd, in north Wales—and I think that Conwy and Denbighshire have a joint safeguarding board. Our work raised questions beyond LSCBs. We mention a number of issues in our report about the effectiveness of LSCBs. Although we did not look at other partnerships, we came away with the clear view that this was not just an issue for LSCBs; it was an issue for how the different partnerships worked together and how effective their arrangements were. There are LSCBs, community safety partnerships, children and young people partnerships, and health, social care and wellbeing partnerships, and you find that there are people who are common to a lot of those bodies in terms of their membership—that is certainly what we found from looking at LSCBs. The boundaries become blurred in terms of responsibilities. In some areas, you find children and young people partnerships taking responsibility for safeguarding and leaving child protection to the LSCBs, with a different arrangement applying in some other areas. Then you had the health service reorganisation, so there are a different number of local health boards, there are four police authorities and 22 local authorities, so we were saying that you get a very complex arrangement emerging.

[175] Our advice was to stand back and think about what the most effective arrangements are if you want to have a clear strategic view of safeguarding arrangements and robust arrangements in terms of ensuring best practice at a local level. We clearly think that this needs to be considered, because it appears to be a very complex model for a relatively small country.

[176] **Peter Black:** Do you think that there is a need for simplification? The children's commissioner has just been arguing for beefed-up LSCBs that are able to take a much more proactive and strategic approach in terms of training and awareness raising, as well as on a

whole range of other issues. Would that be a solution?

[177] **Mr Corbett:** The message from our report is that it is not for the inspectorate to say what the partnership framework should look like, but that it does need to be looked at. In the meantime, local safeguarding children boards should be focusing on making sure that they are operating effectively. Our report shows that they are at very different stages; some are doing a good job, but others are hardly out of the starting blocks. They need to focus on ensuring that they all operate at the level that you would want of them, which is effective for purpose.

[178] **Ms Richardson:** We need to think about separating out where the essential elements of the job should be done. Local safeguarding children boards need a local connection—they need connectivity with their community in order to make sure that they own the responsibility for the safety of that community. This links in with all the other pieces of work that Jonathan has outlined. At a certain level, that connectivity needs to be organised locally, authorised locally and monitored locally.

[179] Then you have to think about their other responsibilities—strategic work, training, the research that they do and the learning that you expect—and think about whether that fits into a different economy. Does that work in a different way, and would it be better for that to be in a wider grouping? There are opportunities to look more carefully at function, rather than looking at form and then fitting function to it. That is a really important distinction.

[180] **Andrew R.T. Davies:** Thank you for this afternoon's evidence. Again on representation, you highlight the variability of membership of, and attendance at, LSCBs, particularly noting that, as a result, people do not have a real understanding of business arrangements. How big an impact does that have and is the situation getting better or worse in terms of the ability to stabilise boards and secure regular attendance?

[181] **Mr Corbett:** I will start and then I will hand over to Imelda. At the time that we undertook the work, there were huge changes going on in the health service and there were some changes happening in the police service, in terms of how it was configured, which created a lot of uncertainty. So, with regard to key statutory members, LSCBs were unsure of who would be at the next meeting and the meeting after that. Whether that picture has changed, we will know from the work that the joint inspectorates are doing later this year. That will give us an indication of where things stand. In terms of its importance, not having those partners around the table is critical.

[182] Another finding from our report was that there was no disagreement, if you talked to any member of the LSCB, that child protection was important, but it did not carry the same priority in every service. If you do not have the same view on priority, it will cause difficulties; we certainly observed that. It is important that people are clear about their priorities and that they act together to ensure that they are carried out.

[183] Other LSCBs were clearly having difficulties in getting people to attend. That requires statutory members to look at how they will tackle the issue. It was very difficult to get certain organisations or representatives to come along regularly, and some thought was needed as to how to solve that.

[184] **Andrew R.T. Davies:** You highlighted the reorganisation of the health service as being a problem. As you said, when you take the next snapshot, that problem will hopefully have been resolved, as that reorganisation should have bedded down. You then touched on other organisations for which it is, perhaps, more of an institutional problem—they either do not take their role seriously or they do not have the resources to fully man their responsibilities. What organisations are you talking of?

2.20 p.m.

[185] **Mr Corbett:** I am not sure whether that is stated in the report. You do not have a clear pattern across every LSCB, so it would vary, and, ultimately, I think that it comes down to the fact that you can put a lot of structures and different things in, but, in the end, it comes down the individuals and the commitment of those individuals and the importance that they place on that. Where you have that situation, what I would expect the other members to do would be to say, 'We need these people here. What are we as a group going to do about that?' They need to enter into some discussions and not just say, 'Well, oh dear, it is unfortunate that this person has not come again'.

[186] **Andrew R.T. Davies:** Do you feel there is that will among the attendees to work collectively to address the problem of serial non-attendees and to get them back around the table, or is it an issue that the local safeguarding boards are not facing up to and hence it could continue to have a rather destabilising effect?

[187] **Mr Corbett:** My assessment would be that it is seen as an issue. Whether there is the will in every LSCB to deal with it, I am not sure.

[188] **Darren Millar:** You made reference to the reorganisation in the health service. You also made reference to some reorganisation within the police service. What reorganisation was that? Was that locally, within certain police force areas?

[189] **Mr Corbett:** Within police force areas, how responsibilities were distributed were reorganised and, therefore, who should go along to the LSCBs.

[190] **Darren Millar:** Did it just happen to tie in with it at the same time?

[191] **Mr Corbett:** It did, yes.

[192] **Darren Millar:** Okay.

[193] **Ms Richardson:** In order to maintain consistency in accountability, as well as the function of the group, full attendance is crucial. That may mean that you need to say that each organisation that you want to see around the table has to have a designated lead and that then becomes a responsibility of the organisation. Within that, some organisations are set up in such a way that somebody may attend for two years and then move on, but at least that gives a two-year span.

[194] If the board itself does not recognise that consistency in attendance is important in maintaining a focus on the priority of the work, then that is a problem. How you assist that, I think, could be through a series of levers within—

[195] **Andrew R.T. Davies:** Would it be fair to say that all the boards would recognise this as a problem or did you detect a bit of a blasé attitude among some boards that that is the way it is and it is the way it has always been? Is there a focus on this in the boards or would you like to see a recommendation for a specific concentration of resources to ensure that the board has a balance on it and full attendance and a lead person from each of the bodies?

[196] **Ms Richardson:** At some point in the life of an organisation that you are trying to set up, like the LSCBs, you have to have a rule to get the attendance and to get the consistency that you want and then, when it is working at its optimum, the rule is less important. So, in that respect, sometimes that is the judgment call across the piece as to whether that is the way to go, is it not? I am not talking now about a Welsh experience, but an experience that I know of from England. We would definitely have judged in that way in relation to how we felt that

children's services were functioning had that not been attended to. I can think of examples of matters that were deferred for a long time because the right people were not attending. I am not saying that that is the situation here. I am thinking of some very bad examples, and we do not want to focus necessarily just on the bad examples. We want to focus on the organisations and the boards that are running really well. So, between those two levers we need to get the focus on why those people are working so well—they are the exemplar and that is what we want you to follow—rather than always using the punishment route.

[197] **Mr Corbett:** You raise a more fundamental issue as well, which is the accountability of these different bodies. The members of the LSCB are accountable to the bodies that appoint them and, therefore, that is where accountability rests. So, in terms of the LSCB being able to exercise any authority to require people to attend, it cannot do that. It does not have the authority to do that.

[198] **Andrew R.T. Davies:** So, the LSCBs are stuck in no man's land, are they?

[199] **Mr Corbett:** What you rely on is a recognition across all the parties that this is important and to do it you need to invest in it, whether that is in kind or in cash, because we also need money to run these bodies. You would have thought that when it comes down to the protection of children there would not be any dispute about that, but it raises the point that I made earlier around the recommendations that were in this report, that nobody disagrees that child protection is important but it is not everybody's priority.

[200] **David Lloyd:** To keep with the role of the LSCBs, but going after a different facet of it, you say in your paper that few safeguarding boards were found to have extended their remit beyond child protection and you say:

[201] 'It was of particular concern that even within this narrow definition of safeguarding, few local safeguarding children boards had set themselves effective multi-agency measures against their activity.'

[202] Do you want to clarify and expand on your concerns on that point?

[203] **Mr Corbett:** If you read both the reports that we published, what we found was that if services were not working together effectively or had other demands on them, the default position when it came to child protection was that it was a matter for social services. That was a very clear message that came through: it is social services' business. That is the default that they revert to.

[204] So, we looked at the work, and, in fairness to the LSCBs quite a lot of them were trying to do work around looking at performance and quality of practice. When looking at performance, we have a fairly robust data set for local authority social services in terms of child protection and there are requirements set out there. They are quantitative measures, as in 'Are you doing this when you are supposed to be doing it?', but they are there. So, when it came to LSCBs saying, 'Let us monitor how we are doing', you have a ready-made data set as far as social services are concerned. Those data sets do not apply to other agencies, so therefore LSCBs are looking very much at what social services are doing, but there is an issue as to whether they are thinking about, 'Well, in the absence of national data sets around this for some other agencies, should we be designing our own local ones?' Some of them were starting to think about that and some of them have subgroups that look at the quality of work. They look at cases and how they track through, but, again, what we found was that they were looking at social services cases, but there was an issue as to whether they were looking across the agencies to see how well they were dealing with that. What we were saying was, 'Okay, you perhaps start in the easiest place where you have the information, but what you really need to focus on next is looking across the board to make sure that we are looking at how all

the agencies work together effectively'.

[205] **Irene James:** I would like to move on to front-line practitioners, because in your report you say that front-line practitioners and team managers were often unaware of the local safeguarding children boards' role in co-ordinating policy and practice. How significant an issue do you think this is and what could be done to help to address the problem?

[206] **Ms Richardson:** If they do not address the problem then you never get any direct learning. So, it is not just that they do not know about the boards and their response in terms of policy, but that when you come to serious case reviews the direct learning from those serious case reviews is not always brought back to the practitioners for them to understand how the organisations in the round have not honoured their duties and responsibilities.

[207] I think that it is about learning, and learning from the very outset in terms of social work courses, with an expectation that people are trained not just on the practical elements of being a childcare social worker but in understanding where the learning will come from within the support arrangements, and to see local safeguarding children boards as part of that support and learning arrangement. At the moment that is completely missing.

2.30 p.m.

[208] **Mr Corbett:** I have to say that I found it quite surprising to learn that you could go through social work training and be employed by an authority as a social worker protecting children, and yet you would not know what an LSCB does or what it is about. In fact, I find that quite worrying. If I were in one of those areas where the workers do not know that, I would be asking questions about how effective the LSCB is, to be frank. That is a worrying finding if people do not know what the board is for or what its role is, and there are clearly some significant communication issues there.

[209] **Darren Millar:** Is that a problem of the LSCB's making, by failing to communicate with front-line practitioners, or is it that certain members of the LSCB are failing to disseminate information coming from the board? Where does the fault lie?

[210] **Mr Corbett:** Sorry to get as basic as this, but if there is a social worker practising in childcare who has not read 'Working Together' and who is not familiar with the all-Wales child protection procedures—in which there are plenty of references to LSCBs, their role and what they do—as my colleague, Imelda, was saying, there must be some problems with the social work training, let alone anything else.

[211] **Darren Millar:** There must be problems with local authorities employing social workers without testing their knowledge, as well, surely.

[212] **Ms Richardson:** Yes. The challenge to the boards is to evidence the learning. That should be a performance measure, because all the research shows that more is being done but less is being learned, and we have to tackle that.

[213] **Darren Millar:** As well as the recruitment processes and so on. Back to you, Dai.

[214] **David Lloyd:** I now want to turn to serious case reviews, which we have touched on already. In your paper, you say,

[215] 'there needs to be a more coherent and comprehensive LSCB framework for reviewing, learning and improving safeguarding practice which does not rely solely on serious case reviews as the driver for achieving change in policy and practice.'

[216] How significant, therefore, are the challenges faced by LSCBs in achieving such a change in policy and practice in response?

[217] **Mr Corbett:** As you will know, the Deputy Minister for Children accepted the findings of our report and has established a wider group to work up some proposals for a new framework. That will encompass what serious case reviews currently do but is much wider, and will consider how we can change the whole culture, learning and approach across organisations and across practitioners.

[218] The fundamental problem that we have with serious case reviews is that they are very costly, they take a long time to undertake and look back over a long period of time, and they suck up vast amounts of time and resources to come up with a report, but it is then very difficult to pin down the resources that are put into addressing the findings. So, I do not think that it is an issue for LSCBs to tackle on their own, as there needs to be clear direction at a Government level to rethink how we do this. Then, it is very much about trying to change hearts and minds, and the culture.

[219] The problem with serious case reviews is that they have become politically very high profile. They are given a high profile in the media, which always looks at when things go wrong, but we happen to know that people learn better from things going well. So, what we need to do is change the culture and the way in which people work so that they learn not only from when they are doing things well, but also from when things have not gone right. They can then identify the issues and learn from that, rather than go into some lengthy process that, ultimately, does not deliver what we are looking for.

[220] **Ms Richardson:** I think that that is an important point. How much have we learned from failure and how much have we failed to learn from failure? There will always be failures, but if, alongside a serious case review where various things had gone wrong, we produced a case example in which everything had been done right to counter it, at least there would be some balance for people to take account of. That would help to move us towards what we want to do, which is to learn and improve services and not always to focus on the blame. Blame produces an environment in which people fail to learn.

[221] **Mr Corbett:** What is important and what has struck me in all the discussions with groups that I have sat in on is the commitment of all professionals to do better. The work that is going on now is doing just that. It is engaging with people across the piece—across Wales and across the professions—to come up with a model that they are signed up to and that will help rather than hinder them. That is really important. People are very committed to improving the current arrangements.

[222] **Peter Black:** Do you think that one problem is that social workers and their managers are under too much pressure to be able to take a step back and look at how they are doing their work, and to identify where things have gone well, so that they can then propagate good practice?

[223] **Ms Richardson:** It is very common to focus on the next problem, because the next problem has already appeared before you have sorted out the first problem. To find the time to recognise, value and learn from successes is very difficult. It is not impossible, but it is really necessary.

[224] **Mr Corbett:** In our reports, when we ask social workers about training and training opportunities, it is not uncommon to get comments that there are plenty of training opportunities—and some very good training is put on—but that they are not always able to attend because some crisis has come up. That is not an uncommon experience, and you have hit on a very important point: to be good practitioners, you need time to reflect and consider

what has been going on and to stand back, and to do that with other people who have also been working with you. That is really important for promoting good learning and better practice.

[225] **Val Lloyd:** In your written evidence, you refer to LSCB joint inspection projects. Please could you tell us more about the timeline and the purpose?

[226] **Mr Corbett:** Yes. We initiated some work about two years ago with a number of other inspectorates across England and Wales, so we are working with the Wales Audit Office, Estyn, Health Inspectorate Wales, HM Inspectorate of Constabulary and HM Inspectorate of Probation. Those are the bodies that we are working with. We brought those groups together, because we looked at the requirements under the Children Act 2004 and we got agreement with those bodies that, under section 30, we would first of all look at LSCBs and we would then go on to look at the partnerships.

[227] We planned the work with LSCBs before what happened in Haringey, so it was already programmed to take place. However, given the situation in Haringey, we took only a quick look. What we have referred to now is the further work that we are doing, and that is part of a programme that we have been leading from the inspectorate for the past few years. It is a developmental programme for LSCBs. That has involved commissioning work to develop a self-assessment and improvement tool for LSCBs, which has a number of areas and standards that they have to use to assess and benchmark themselves.

[228] That has been developed in consultation with the LSCBs, and they have all gone through that process of undertaking the first assessment. We have asked them for that information so that we can look at it with the other inspectorates and get a focus for our first piece of work around a joint inspection of looking at the LSCBs. That is planned for the end of this year and the beginning of next year, so we will be publishing a report probably in the spring of next year, which will be from all the inspectorates, having looked at the self-assessments for all the LSCBs and having visited a fairly large sample of them, to look at practice and the arrangements for running the LSCBs.

2.40 p.m.

[229] One the difficulties with the Haringey work was that we had to undertake that work fairly quickly. It was not possible to work with all the other inspectorates in doing that. We did work with HIW, but we could not do all the work with the others in such a short time and we already had this programme planned. So, we will do that in relation to the LSCBs and report probably around spring or early summer next year, and then we will be looking at a similar approach and what lessons we have learned from that in terms of the children and young people partnerships.

[230] **Val Lloyd:** Thank you. That is very comprehensive.

[231] **Andrew R.T. Davies:** On the self-audit and improvement tool, ACPO touched on the fact that there was little scrutiny by the Welsh Assembly Government of the follow-up after the assessments that had been made by the various bodies. What is your assessment or take on that?

[232] **Mr Corbett:** Well, this piece of work was approved by the Welsh Assembly Government, and it was developed in close conjunction with all the LSCBs, including the police. It has been very widely welcomed by all the LSCBs, including the police. All the LSCBs have now completed that and they have all submitted their self-assessments to the joint inspectorates. Rather than getting them to do a separate self-assessment for the purposes of inspection, we are using that as a basis for looking at what areas we want to follow up with

them.

[233] So, in terms of engagement, they have been involved. The police have been involved all the way through in the development. The police have been involved in undertaking the self-assessments. They have to be, because that is part of the self-assessment: are all the agencies working—

[234] **Andrew R.T. Davies:** I think that the point was not so much about the self-assessment, but the ability to audit whether the self-assessments were robust, shall we say, and, for the improvements that maybe the self-assessments indicated needed to be undertaken, what follow-up was taken to ensure that those improvements were put in place?

[235] **Mr Corbett:** Okay. The self-assessments have only just been completed. They have been sent in to us and we will be going out later this year with HMIC to look at what they are doing about that. The self-assessment tool, which asks them to rate themselves and put in a benchmark, has been very helpful because it has enabled them to have some pretty focused discussions, where there is no hiding place in terms of, 'Are we doing this or are we not and what are we going to do about it and where are we going to prioritise our work?' So, I think that it has given them a focus.

[236] The issue will be what the LSCBs now do with that in terms of asking, 'How are we going to reflect that in our forward business plan and address those areas?' Our report will be able to comment on whether or not they have been successful in doing so.

[237] **Darren Millar:** Did you say they have only just been completed? It seemed to me that they had been completed some time back for many of the LSCBs.

[238] **Ms Richardson:** No, they have not.

[239] **Darren Millar:** Have they not?

[240] **Mr Corbett:** The tool was only launched in May last year. When it was launched, alongside it we made money available to put a programme in place for every LSCB to understand how it is used. So, before they even started using it we put something in place to say, 'Here is the tool, now let us go through it with you to be sure that you are clear about how you use it', and they only started using it in the autumn.

[241] **Andrew R.T. Davies:** I would just like to take that up, because ACPO's own words are:

[242] 'There is little scrutiny from the (Welsh Government) in relation to the work plans/areas for improvement that should have followed this self assessment process.'

[243] So, it would seem as if maybe that statement was a little premature as the self-assessment tool is in its infancy, or am I misunderstanding something?

[244] **Ms Richardson:** No, you are not. It is year one of that self-assessment tool. The previous work was around the training for the use of the tool. So, this is year one and it sets the benchmark. I have to say that the tool itself is very smart. It was sponsored by the Welsh Assembly Government. It is Welsh Assembly Government copyright and it is supported by academic rigour, so I would not be surprised if people wanted to buy it from you.

[245] **Andrew R.T. Davies:** So, is that criticism by ACPO unfair?

[246] **Ms Richardson:** Absolutely, because the process has not yet finished for that first

year.

[247] **Darren Millar:** Let me just say there has been no criticism of the self-assessment tool itself; in fact, it has been welcomed by witnesses. We just needed to clarify that point; I am sure that you understand. Irene James has the final question.

[248] **Irene James:** As part of the inquiry terms of reference, the committee is reviewing the effectiveness of LSCBs in promoting the protection and welfare of specific groups of vulnerable children: black and minority ethnic children, trafficked children, asylum seekers and children with disabilities. So, did your review find any evidence that LSCBs were less effective in their role in protecting a specific group of vulnerable children?

[249] **Mr Corbett:** Well, the piece of work that we did last year was a pretty quick look at how effectively they were working overall. When you come to look at particular vulnerable groups, what I would look to is the report that we produced in February last year, I think. We published a report on arrangements for privately fostered children in Wales. What that found was that they are an incredibly vulnerable group, probably one of the most vulnerable, and the evidence was that LSCBs were not fulfilling the functions that you would expect them to in relation to privately fostered children.

[250] So, I use that as an example of where we have some clear evidence that they were not doing what we would expect of them in terms of wanting to know how many privately fostered children there were and what arrangements there were to protect those children and ensure they are safeguarded. They were not doing that as they should have done and we raised that in the report and that is an area that we will probably follow up when we do this work with the other inspectorates.

[251] In terms of other groups of children, we have not looked specifically at what work they are doing but, again, if you take vulnerable groups as a whole then that will be part of the work that we do in the coming year.

[252] **Darren Millar:** That brings us to the end of this part of the meeting. Thank you for the written evidence and the oral evidence which you have provided us with. If there are any other bits of information that you want to send on to us we would be very grateful to receive that as part of our inquiry. Thank you very much.

[253] We will take a short break before we receive our next witnesses and I can assure Members that we will finish the meeting on time.

Gohiriwyd y cyfarfod rhwng 2.47 p.m. a 2.51 p.m.
The meeting adjourned between 2.47 p.m. and 2.51 p.m.

Ymchwiliad y Pwyllgor i Fyrddau Lleol Diogelu Plant yng Nghymru: Tystiolaeth gan y Bwrdd Cyfiawnder Ieuenctid Cymru a Lloegr
Committee Inquiry into Local Safeguarding Children Boards: Evidence from the Youth Justice Board for England and Wales

[254] **Darren Millar:** We will continue with our meeting. We will take item 5, continuing with the inquiry into local safeguarding children boards. I am delighted to welcome representatives from the Youth Justice Board for England and Wales this afternoon. Sue Williams is the head of the youth justice board in Wales, and Steve Dobson is the head of Wales workforce development and social care. Thank you very much for the written evidence that you have already provided us with. We appreciate that. If you are content, we will go straight into questions on that written evidence.

[255] How effectively do youth justice services in Wales engage with local safeguarding children boards? What are the main challenges that you face in that engagement?

[256] **Ms Williams:** I will start and hand over to Steve, if that is okay. The information that we have is in the annual plans that youth offending teams have to submit to us. I have to say that the last complete plans that we have refer to the year 2008-09 because, last year, we were developing a new model. So, we are currently in the throes of validating new sets of detailed plans even as I speak. On the basis of the information that we have, all YOTs tell us that they are fully engaged with local safeguarding children boards—the YOT managers are statutory members.

[257] Thinking of the patterns of engagement with other partnerships across Wales, in terms of the variability of whether what is supposed to be delivered is delivered and so on, it would probably be foolish to believe that that means that, in practice, each one of them is engaged perfectly and it works wonderfully across all 18 youth offending teams. If you were to ask me, I would have to say that I suspect that it is quite variable across Wales. I do not yet have the detailed evidence to know that for sure and to be able to say, 'I know that in areas A, B and C it works quite well, and then in areas D and E it is not good enough'. However, I will have that evidence in about two months' time and I will be able to add a lot more detail to that.

[258] **Darren Millar:** You say that you suspect that there is some variability within Wales. How do you think that the engagement in Wales compares with that over the border in England?

[259] **Ms Williams:** I do not think that I can answer that question; I really do not know.

[260] **Darren Millar:** That is okay. Thanks for being honest about it.

[261] **Irene James:** I would like to look at the role and scope of LSCBs. How satisfied are you that the scope and focus of the responsibilities of LSCBs are appropriate in relation to children and young people in the youth justice system?

[262] **Ms Williams:** I will start and then I will hand over to Steve because he is well versed in the detail of it. On the whole, as set out in guidance and statute and so on, we are reasonably happy with the extent to which youth offending teams and the children and youth justice system are included, with some small exceptions. I think that the question is probably more about what that means in practice rather than whether the actual regulations, guidance and so on are inclusive enough on that point. However, I think that I will hand over to Steve for him to provide more of an answer.

[263] **Mr Dobson:** There are some interesting challenges around the guidance given to LSCBs on making sure that they are clear where youth justice fits within the safeguarding agenda in Wales. I know that you are interested in the guidance and how it impacts on the work of the LSCBs and the various groups, such as vulnerable groups, which often include children involved in the youth justice system. From our perspective, there are some very good things in the existing guidance that could be developed and brought up to date to reflect the current competencies of the Welsh Assembly Government and the structures of where we are now in Wales in 2010, rather than saying that the guidance just needs to be torn up and thrown away. I think that it is about building on what exists and enhancing it.

[264] In terms of the role of the LSCB, locally I think that there is a significant challenge around where the LSCB sits in relation to the YOT management board, which is itself a statutory partnership. We would certainly hope that, in future guidance, the YOT

management board would be referred to and reflected in any illustration of the complexity of local partnerships and how they need to interconnect and relate to each other. Unfortunately, the current guidance includes the community safety partnerships and the children and young people partnerships, but leaves out any reference to YOT management boards. In terms of the YOT management being involved with the LSCBs, as we say in the evidence, that clearly needs to be maintained. There is a key role there.

[265] On engagement, as Sue has said, there is an issue of how consistently they are engaged and who engages. We hope to know more about the picture in Wales in a few months' time. Simultaneously, we would hope that our colleagues in England would be able to come up with evidence about engagement in England because the two models of how we assess and monitor youth offending services are paralleling each other and we should be able to get similar evidence. So, if it would be helpful, we could bring that evidence to the committee at a later date when we have done it.

[266] **Irene James:** Yes, it would be.

[267] **David Lloyd:** I also sit on the Assembly's Communities and Culture Committee, and you will be aware of the review that that committee did a few months ago into youth justice and the secure estate. As a committee, we found tremendous variation in custody rates relating to young people in different parts of Wales. So, in terms of the role of the LSCBs, in your experience, to what extent are the local safeguarding children boards responsible for analysing such issues as the high number of looked-after children in the youth justice system and the high use of custody in certain parts of Wales?

[268] **Mr Dobson:** I know from the internal monitoring that the youth justice board does of the secure estate in Wales that the LSCB in Bridgend has a good working relationship with Parc prison and the unit there. Similarly, for Neath Port Talbot, there is a local authority secure children's home at Hillside. There are good working relationships.

[269] There are issues about LSCBs owning children who are in the secure estate—the home LSCB, I mean—in the sense of recognising that they have a responsibility to maintain a watching brief on what is happening to their young people when they are in secure accommodation, whether that is in Wales or in England. It is important that the need to recognise their role in ensuring the safety of young people from their home locality in Wales, who are in secure establishments in England, is brought to their attention.

[270] **Andrew R.T. Davies:** You talk about the good strategic engagement between youth offending teams and local safeguarding children boards. How do the practitioners and the youth offending teams develop an understanding of the workings of the safeguarding children boards? Is that relationship as good as it is at the strategic level or does work need to be undertaken on that?

3.00 p.m.

[271] **Mr Dobson:** The youth justice board has approached the issue of ensuring that practitioners are aware of the LSCB, its role and its function, through our qualifications and by way of a training website, to which all staff have free access. Safeguarding and the role of LSCBs is covered in our qualifications and in the professional development modules on that website, and we try to support and promote an understanding among front-line staff in that way. By doing that and by making that available, we support management in ensuring that their staff are fully aware of their responsibilities for safeguarding children on an individual practitioner basis.

[272] **Andrew R.T. Davies:** Are you confident that that level of engagement is sufficient

to meet the needs of front-line practitioners in understanding the roles?

[273] **Mr Dobson:** I am sure that there is more that we need to do. One thing that we are considering at the moment, as an organisation, for our next three-year workforce development plan is what, if anything, we need to do around safeguarding to up our game even further. We want to be supportive of local services and LSCBs in making sure that, within the youth justice profession, people are fully aware of their responsibilities for safeguarding and, in particular, for the child protection of victims, people in the community and young people who have involvement with the youth justice system.

[274] The other piece of evidence that I would like to give to the committee is around the involvement of youth offending services' staff in local training, particularly that provided by the local authority, on child protection and the broader safeguarding agenda. I know that they have access to that training and are involved in it. Therefore, staff who need it can get very detailed training on child protection and, more broadly, on safeguarding. There is an issue about LSCB oversight on the impact of that training and its availability. I know that you have heard from others about the challenges for front-line staff in being released for training and in accessing the right training for their role; that is something for us to explore further as an organisation.

[275] **Val Lloyd:** I want to explore the relationship between the LSCBs and the youth offending team management boards. You tell us that YOTs are represented on the LSCBs at a senior level, and that they are members of a range of local partnerships. How confident are you that youth offending team management boards are able to contribute effectively to local safeguarding children boards and that the organisation has sufficient capacity for them to do so?

[276] **Mr Dobson:** There is an important issue here around leadership. One thing that we are very keen on is that YOT management boards very much lead the youth justice agenda in their locality and then work with other partnerships to lead on the broader agenda of safeguarding children and child protection. On a local basis, there is a need for YOT management boards and LSCBs to work out how they work together, and that might be supported by Welsh Assembly Government guidance on the need for that interface and how it should work.

[277] I know that you have been taking advice from other people on the importance of strengthening the guidance around how partnerships work together. You have also heard that it is a complex arrangement, locally—many of these are local services, there are some services that are on non-devolved functions, like youth justice, and there are some services that are non-devolved. That complexity is something that the Welsh Assembly Government will need to reflect on for any steer or guidance that it gives to partnerships.

[278] At the moment, we provide guidance to YOT management boards urging them to be active participants of local safeguarding children boards. As Sue said, how much they do that does vary; it is a mixed picture. We have recognised the need to update our guidance to YOT management boards—we are working on a project in Wales specifically on that and there is similar work going on in England. We recognise the need to reflect, if you like, on where we are now, what the structures are and what the challenges are. The latest reports from the inspectorates are helpful for us in that.

[279] As you may know, inspectors of probation have been undertaking a five-year programme of inspections of YOTs, and the programme report was published last year. That includes significant elements around safeguarding, and we are driving forward work to try to move those issues forward with YOT management boards, YOTs and others.

[280] At the moment the probation inspectorate is looking at how youth offending teams manage their cases. It is an intensive programme, with all 18 YOTs being inspected at the moment. By September, we will have a report for Wales and individual reports on all YOTs. One-third of the criteria for that inspection programme is about safeguarding.

[281] Having looked at some reports on English YOTs, by September we will have a wealth of information about how, at a practitioner level, cases are managed. From that, we will have some inferences about what goes on at management level, including YOT management board level, to make sure that young people are safeguarded and we will know how well the partnership works at safeguarding young people.

[282] **Darren Millar:** You mentioned the fact that not all partners sitting at the table at local safeguarding children boards represent devolved services. If the Assembly Government was to issue guidance on your participation in a local safeguarding children board, would you take heed of it? You would not have to; you could ignore it if you wanted to, could you not?

[283] **Ms Williams:** It would be on youth offending team managers' participation, who would have to take heed, because they are employed by the local authority anyway.

[284] **Darren Millar:** Okay, so would you have to take heed even though it is part of the justice system.

[285] **Ms Williams:** Yes.

[286] **Darren Millar:** I see. So, would you have to take heed of that guidance?

[287] **Ms Williams:** The youth offending team is a statutory partnership led by the local authority chief executive, so they would comply under the general local authority umbrella. There may be side issues for the probation and police statutory members of the partnership, but they would not be different, in the wider sense, to how you ensure that police and probation services, which are not devolved, fall into line with how you want them to fall into line.

[288] **Mr Dobson:** We are fortunate in having the Wales youth offending strategy and a joint youth justice committee for Wales. That is a vehicle by which guidance can be given additional strength and impact, if you like; an organisation like ours, with our statutory duty to monitor the performance, disseminate effective practice and work with YOT management boards, could ensure that youth justice joins in fully with the safeguarding agenda.

[289] **Lorraine Barrett:** You state in your written evidence that youth offending teams have trouble in accessing children's services on behalf of children and young people despite increasing integration at a strategic level. So, how effective are the LSCBs in promoting the protection and welfare of some of the most vulnerable children in the youth justice system?

[290] **Ms Williams:** I think that we will have more detailed evidence on this once we have finished two things: our current validation of YOT self-assessments, and when we know the results of 18 individual inspections, led by HM Inspectorate of Probation, of youth offending teams and their safeguarding and risk of harm practices. Do you want to add anything to that?

3.10 p.m.

[291] **Mr Dobson:** What we are doing in Wales within the youth justice board is trying to ensure that the agenda around safeguarding is taken forward within our sector and that that is done in collaboration with the statutory partners and the partnerships in each locality. Our youth justice board member for Wales has been involved with the Minister, the Deputy

Minister and also the director of social services within the Welsh Assembly Government at a very high strategic leadership level to try to take forward the agenda to make sure that LSCBs and YOT management boards and YOT management work together to safeguard young people.

[292] We have work planned with ADSS Cymru, the Welsh Local Government Association, Her Majesty's Inspectorate of Probation and so on to try to take forward the findings that are already in existence about LSCBs and how they operate within the youth justice world and how they operate generally within the partnerships world. So, what we are trying to do is play our part and make youth justice play its part in taking forward the safeguarding agenda.

[293] **Lorraine Barrett:** I do not know whether it is easy for you to do this, but can you say why there is this problem? I know that you say you have to wait, but what is the stumbling block or the barrier that stops YOTs from accessing those services in the way that you have reported? Is there a silo mentality?

[294] **Ms Williams:** Our comments are based on the findings of the last cycle of inspections, which was a five-year programme. Steve and I analysed all the inspection reports. That was a piece of work that we agreed to do with Graham Williams when he was director of social services, and we have carried it forward, talking to Rob Pickford about it.

[295] The first thing to say is that it was not something that the inspectors found in all youth offending teams; it only applied to some of them. There are a few issues. First of all, it is stated that, in some areas, the thresholds are too high, basically. That is stated baldly in the summary report. So, the thresholds are set too high to encompass all of the vulnerable children that need to be encompassed. There was also an issue in some places that youth offending team staff were not well versed enough in safeguarding practices, so we have started to look at that.

[296] There is also an issue about local leadership, and I think that you have heard other witnesses talk about the priority that is given to safeguarding and child protection. Everybody will say that it is important, but, in reality, it is sometimes not seen as important as some other things. I am sure there was a fourth point, which I have forgotten.

[297] **Mr Dobson:** There are issues about the pressures, which I know that you have heard about this afternoon, that front-line services face when it comes to child protection and so on, and there are a number of ways, which are mentioned in the CSSIW report, in which services then respond in order to manage that pressure on their finite resources. We are keen to get the message across that this is not a case of us saying, 'Youth justice good. Social services or children's services bad'. It is about the two sides needing to work together, and that is one of the priorities for me in this new role that the youth justice board has created around trying to move forward the social care agenda in Wales.

[298] **David Lloyd:** Turning to secure accommodation, you have touched on these issues already, but can you just spell out how confident you are that LSCBs understand their continuing responsibilities in relation to children and young people in the secure estate?

[299] **Ms Williams:** I am pretty confident about the LSCBs in Bridgend and Neath Port Talbot understanding their responsibility in relation to the secure establishments in their areas, but not so confident about each LSCB understanding its responsibility for children from its area who are placed in secure accommodation elsewhere. Again, we need to collect evidence on this, but my best guess would be that it varies and that in some places LSCBs make a point of considering children in custody while other LSCBs do not actively consider them at all. We would like to see greater priority given to a specific consideration not only of

children in custody wherever they may be placed, but also of children who are at risk of custody. We would like to see that given particular scrutiny.

[300] **David Lloyd:** Fine. That takes care of the issues that I wanted to ask about.

[301] **Darren Millar:** I think that it does, you are absolutely right. So, when a child is in a secure facility outside of an LSCB's area and it is a child for which that LSCB is responsible, is it responsible for, effectively, checking that the secure accommodation and the facilities there are appropriate?

[302] **Mr Dobson:** Yes, it has to be.

[303] **Darren Millar:** Is that the case even though there could be 10, 15 or 20 local authorities all checking those facilities? Is there not a bit of duplication there?

[304] **Mr Dobson:** I think that the LSCB that has the secure accommodation in its territory needs to work out with the other local safeguarding children boards how it manages concerns about an individual child.

[305] **Darren Millar:** So, how is that done at the moment? It just seems barmy, if there is a secure facility with lots of young people in and they have been sent there from all over the country, that they will be monitored by all of these different LSCBs. Is that really a good idea?

[306] **Ms Williams:** That would not be any different from the situation with any child placed outside of their local authority area. If a child is placed away from home in a children's home or private fostering facility, then the home area would check up on the progress of that child.

[307] The role of the LSCB is in relation to the individual child's welfare rather than in relation to the facilities of the secure establishment, because that is separately regulated. The LSCB in the area where the establishment is based has responsibilities for certain aspects of the regime with regard to children's welfare. Certainly, Bridgend is fully engaged; the local authority is fully engaged in arrangements around Parc prison.

[308] **Darren Millar:** Do you think that that is satisfactory?

[309] **Ms Williams:** Well, I do not think that it works perfectly in practice, in the same way that there are problems associated with that model in general, whether you are talking about secure accommodation or other types of child placement. There tends to be duplication and overlaps.

[310] **Darren Millar:** So, it may not be efficient, but it is the system that we have and we have to work with it, is that it?

[311] **Ms Williams:** Yes, exactly.

[312] **Mr Dobson:** It does raise the question of whether there are sufficient mechanisms at an all-Wales level to enable those issues of potential overlaps, duplication and so on to be resolved, and that might be an issue that the committee would want to reflect on.

[313] **Darren Millar:** It is just interesting to see whether there is an efficient use of resources there, while obviously wanting to safeguard the child who is in those sorts of facilities.

[314] **Peter Black:** I am just a bit confused. We are talking about local safeguarding children boards having responsibilities, but the individual constituent parts of the boards have the responsibility. The boards themselves have the strategic overview and drive forward practice and review and improve. That is right, is it not? So, in the case of the secure estate, the relevant body that manages that estate and perhaps the social services department and those bodies that come into contact with the child will have the responsibilities, as I understand it.

[315] **Ms Williams:** Yes. Steve is the expert on the guidance, and I think that there is something separate about LSCB responsibilities in there.

3.20 p.m.

[316] **Mr Dobson:** What we are urging is that there should not be a situation where a young person moves out of a locality into secure accommodation and the LSCB thinks that it does not have any continuing responsibility for that young person.

[317] **Peter Black:** Do you mean the social services department thinks that it does not have a continuing responsibility?

[318] **Mr Dobson:** No, this is within the functions of the LSCB.

[319] **Peter Black:** The LSCB does not manage individual cases, though, does it?

[320] **Mr Dobson:** No, but if, say, there is a serious event—

[321] **Peter Black:** Yes, it clearly has responsibility for that.

[322] **Mr Dobson:** Yes, and that is the context. It is not the minutiae of day-to-day existence that we are referring to here, but more that high-level strategic ownership. I go back to the corporate parent concept.

[323] **Peter Black:** So what you are suggesting is that local safeguarding children boards should be putting together policies to ensure that the various constituent parts keep in touch with children who are placed outside of their areas. Is that right?

[324] **Mr Dobson:** Yes, it reflects on the issues around corporate parenting.

[325] **Darren Millar:** Or that they are reminded that they have not discharged their duty towards that child.

[326] **Peter Black:** Yes. The area that I am talking about and that I have questions on is the secure estate outside Wales—clearly, there are a large number of young people who are in secure facilities in England—and the particular problems with keeping in touch with those children, which were highlighted by the youth offending teams when they gave evidence to the Communities and Culture Committee. How effective is information sharing between the various responsible bodies when the child is not just outside the local authority area but across the border?

[327] **Mr Dobson:** There is within the youth justice board a safeguarding children in the secure estate group, of which I am a member, which tries to ensure consistency across England and Wales in how the safeguarding agenda is put forward and progressed.

[328] I have just lost my train of thought. My apologies. I think that the issue is about ensuring that the secure accommodation in England and Wales, because it is accessed by

young people from Wales, offers a consistent service across the two countries, and that is very much what the youth justice board perceives and desires the service to be. One of the ways in which we drive our commissioning function is to try to ensure that where the young person is does not have a detrimental effect on the quality of the safeguarding or the quality of the service and so on and that there is consistency.

[329] **Peter Black:** Clearly, when someone is in a secure institution the responsibility for the safety of that young person lies with the local authorities in that area, but the issue here is discharge, in many ways: is that person going to be discharged to a safe environment, how is that going to be managed, and so on? That is where you have to get the right communication between the area where that person is being detained and the area where that person is going to be discharged.

[330] **Ms Williams:** The overall good news on this is that the number of children in custody has fallen by 25 per cent over the last year, so there are currently about 112 Welsh children in custody, sentenced and remanded, and half of those are in Wales. So, you are talking about 55 or 60 Welsh children who are in custody but not in Wales. I think that you are right that resettlement of children from custody is a problematic area, and it is problematic because of the difficulties in joining up and following through services inside and outside the establishment and ensuring that services are in place when the young person is released.

[331] We are funding currently six new resettlement support panels throughout Wales, which are looking at exactly that: preparing for a young person's release, ensuring that all the agencies that need to be engaged are engaged, and that the young person has a proper, supportive package so that the young person gets the best possible start on leaving custody. That is not a perfect answer. They are pilot projects, and we want, if possible, to see them rolled out further. We are also having them evaluated.

[332] **Peter Black:** Is this a piece of work that the local safeguarding children board could be engaged in?

[333] **Ms Williams:** Yes. I cannot quote you chapter and verse on the guidance that we produced around these pilot projects, but it is stated in the guidance that there has to be that link to the LSCB.

[334] **Darren Millar:** The final question is from Irene James.

[335] **Irene James:** I think that you will be very relieved to hear that this is the last one. To what extent might better use of serious incident reports help LSCBs to improve the effectiveness of their role?

[336] **Ms Williams:** Do you mean the youth justice board serious incident reviews?

[337] **Irene James:** Yes.

[338] **Ms Williams:** I will just make sure that you know, because you probably will not have seen detail on the YJB's serious incident model, that, compared to, say, a serious case review, for example, it is an extremely light-touch thing. It is designed deliberately to be non-bureaucratic and to allow for the level of reporting under it that is appropriate for the incident or the involvement of the youth offending team that has taken place.

[339] I think that what we say in guidance is that the serious incident reviews should be shared with the local safeguarding children board so that lessons learned can be tied in fully and everybody can look at them. Again, I doubt whether that happens in each case as it

should do in every area of Wales. I will know more about that, with practical examples and so on, in a few months' time. Does that answer your question?

[340] **Irene James:** Yes, that is fine.

[341] **Darren Millar:** That brings this part of our meeting to a close. Thank you both for the evidence you have provided, both written and oral, today. If there are any further bits of information that you want to pass on to us such as those that you indicated to us earlier on, we would appreciate that to help our inquiry along.

[342] **Ms Williams:** Thank you.

[343] **Mr Dobson:** Thank you very much for the invitation.

3.27 p.m.

Cynnig Trefniadol
Procedural Motion

[344] **Darren Millar:** I move that

[345] the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37.

[346] Are there any objections? I see that there are none.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 3.27 p.m.
The public part of the meeting ended at 3.27 p.m.