



Mid & West Wales Youth Offending Teams (YOTs)

Community Safeguarding and Public Protection Incidents (CSPPI) Policy and Procedure

**THE MID AND WEST WALES
SAFEGUARDING BOARD**

Version	Revision Date	Owner	Date approved by Exec Board	Review Date
V1	17/10/21	Mid and West Wales Safeguarding Board	17/10/2019	17/10/20

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Community Safeguarding and Public Protection Incidents

1. Introduction

On the 8th May 2018, the Community Safeguarding and Public Protection Incidents (CSPPI) reporting responsibilities by Local Authorities to the Youth Justice Board (YJB) ceased. Decisions about whether/how to review incidents and relevant services being delivered to affected children are now required to be taken locally, following multi-agency discussions, wherever appropriate.

As a result a **learning and Review Framework** has been developed with the intention that the Mid and West Wales Regional Safeguarding Board (CYSUR) and their partner agencies provide an environment in which practitioners and their agencies can identify opportunities to reflect on cases and learn lessons where appropriate.

Working Together to Safeguard People: Volume 2: Child Practice Reviews; SSWA (Wales) 2014 provides a framework to undertake Child Practice Reviews.

A concise '**Child Practice Review**' should be considered, if the child was neither on the Child Protection Register nor Looked After on any date during the 6 months preceding: - Where

Abuse or neglect of the child is known or suspected and the child has-

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health or development.

If the child was on the CP Register and/or was Looked After (including a care leaver under the age of 18) on any date during the 6 months preceding the above incidents, then an '**Extended Child Practice Review**' must be considered.

Consideration of Child Practice Reviews is made by the Child Practice Review Sub-Group of CYSUR usually but not exclusively on referral from Local Operational Groups (LOGs) based in each of the four counties.

However, for the purposes of the CSPPI process, it is likely the majority of cases triggering this procedure will require the convening of a '**Multi-Agency Professional Forum**' (MAPF). This is a continuous CYSUR programme that supports multi-agency reflective learning. A Regional Framework for this process has been developed and any regional learning identified by MAPF is overseen by the Regional MAPF Forum.

For clarity, the generic and legal term 'Youth Offending Team/YOT' will apply to the various Youth Justice Teams and Services within Mid & West Wales. When a child/young person on the Youth Offending Team (YOT) caseload (including Out of Court Disposals) is involved (or is alleged to have been involved) in a safeguarding or public protection incident, it is important that any evaluation of the related circumstances takes account of the interplay with any wider agencies and does not just focus on the role of the YOT. Services can include (but are not limited to) Children's Social Care, Education and Health. The YJB advocates an approach to learning from serious incidents which focuses on the journey of the child rather than on the perspectives of individual service providers and therefore encourages joint working and learning wherever possible.

- The purpose of this document is to set out what staff working in the YOT are required to do if a child is involved in a Safeguarding or Public Protection incident whilst under the supervision of or on the YOT caseload and including those young people not under the

YOT supervision when they were charged;

2. Identification and local notification of CSPPI Incidents

It is the responsibility of the YOT Service Manager or Operational Manager to identify a safeguarding or Public Protection Incident and notify the following within 24 hours: -

- Chair of the YOT Management Board and/or other relevant designated officer
- Chair of Local Operational Group/Head of Children’s Services
- Director of Education/Chief Education Officer
- Head of Service with YOT portfolio

The notifications **must** take place if a young person is: -

- Charged with committing one of the following public protection offences, including those young people not under the YOT supervision when they were charged;
- Involved in a safeguarding incident while on the YOT caseload or up to 20 calendar days following the end of YOT supervision.

The table below identifies the reportable incidents:

SAFEGUARDING	PUBLIC PROTECTION
Young person under YOT supervision/ caseload (or within 20 calendar days of the end of the YOT supervision): -	Young person (whether under YOT supervision/caseload or not) is charged with: -
Dies	Murder/ manslaughter
Attempts suicide (informed by assessments from health clinicians or local mental health professionals) Annex 5	Rape
Is the victim of rape (where an allegation has been made to the police)	A MAPPA serious further offence when the young person is already subject to MAPPA
Is the victim of sexual abuse/exploitation	A Terrorism related offence, including any offence under Terrorism legislation or an offence conspiring, attempting, aiding, abetting, counselling, procuring or inciting and offence under terrorism legislation.(Annex 2)
Has sustained a potentially life threatening injury (either sustained by the action of others, or caused by misadventure) risk taking anti-social behaviour or self-harm	
Has sustained serious and permanent impairment of health and development (Annex 4)	

The YOT must ensure where relevant, that appropriate measures have been put in place to ensure safety and wellbeing of children, young people and adults affected by the incident.

Safeguarding and public protection incidents often attract media attention. Mid & West Wales YOTs must follow Local Authority procedures on handling media. Where a local incident becomes a national issue, it is possible that further detail will be sought by the YJB (within the remit of their whole-system monitoring responsibilities, Crime and Disorder Act 1998). In the event a case attracts or is likely to attract significant media attention the relevant Youth Offending Team Senior Manager should notify and liaise with the Regional Safeguarding Board Manager so any media releases can be managed and co-ordinated appropriately.

3. Local decision making

Following notification of a CSPPI by email entitled 'Urgent – Critical Safeguarding & Public Protection Incident', the Chair of the YOT Management Board, the Chair of the LOG, together with the responsible Head of Service for YOT, will decide if the incident requires a review of YOT practice; the YOT Service Manager will record this decision as a 'management oversight' contact against the relevant case record. This decision making process may happen by email but the YOT Service Manager will attach the email decision making record to the electronic case record. The case and any recommendation to proceed to a MAPF will be discussed and agreed at the next Local Operational Group.

The YOT will make arrangements for the case to be appropriately risk managed/safeguarded to include any required actions e.g. increase levels of contact; referrals to other appropriate agencies etc. in line with their local Risk Management framework.

The review of YOT practice will follow the Mid and West Wales Wales Safeguarding Board's MAPF framework. The process will be led by the appropriate YOT team. In the interests of impartiality a neighbouring YOT can be requested (if deemed appropriate by the LOG Chair & Management Board Chair), through reciprocal arrangements, to undertake the review. The report writer/lead reviewer will normally be an Operational Manager. Partner agencies will be required to provide relevant information to the reviewing officer and assist where necessary with the review timeline. When complete the MAPF Report and agreed action plan will be shared with the Chair of the YOT Management Board and the Chair of the LOG for further consideration and action as appropriate. The MAPF will fall under the jurisdiction of the LOG by local arrangements who will assume responsibility to share any lessons learned locally and implement any action plan in conjunction with the YOT Management Board. It is anticipated that in most cases any wider learning will be captured in the Regional MAPF forum.

Where the LOG feels a case meets the threshold for a referral to the Child Practice Review Sub-Group and a review is undertaken the CPR process will take precedent.

Learning from the young person

When reviewing incidents, it is important to give the young people involved an opportunity to share their views about what happened and to work with them to identify and put in place the support and protective factors that will help keep them safe and prevent future incidents. Consideration needs to be given to who is most appropriate to carry out this function by each YOT Management Board.

4. Multi Agency Professionals Forum (MAPF)

- The Mid and West Wales Regional Framework for undertaking MAPFs will be followed.

- The time, date and venue will be arranged by LOG administration.

In attending the MAPF, each agency must ensure that they are represented whenever possible by practitioners and managers who can positively contribute to the review and any possible learning and practice recommendations that may arise from the forum. The purpose is to identify learning for future practice through exploration of the detail and context of agencies' work with a child/young person and their family.

The output from the forum is intended to generate professional and organisational learning and promote improvement in future inter agency safeguarding and public protection practice.

5. Sharing learning outcomes and recommendations

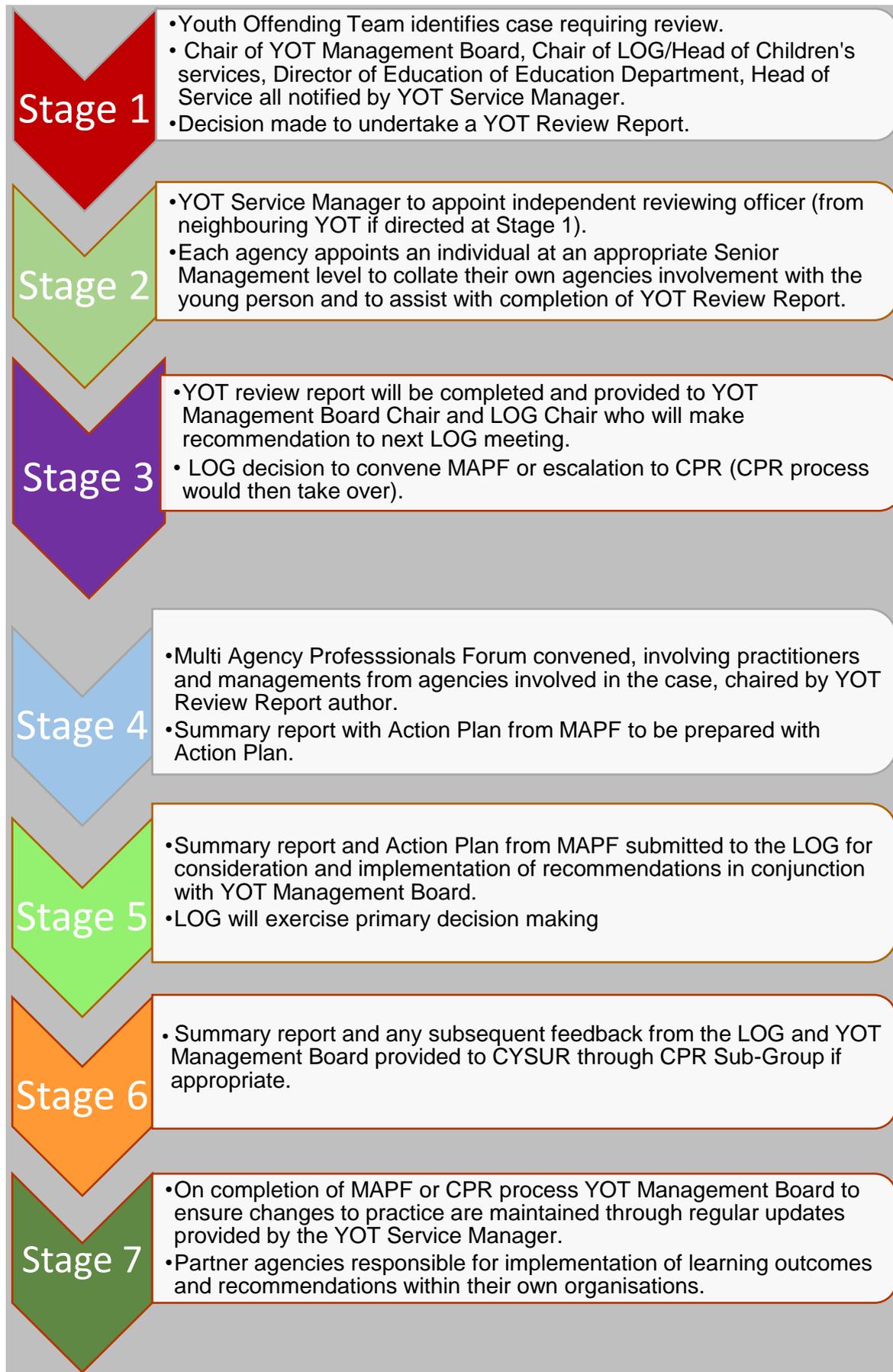
It is important that lessons learnt following serious incidents are shared so that actions can be taken to work to prevent similar incidents from happening in the future.

A summary report of the learning outcomes and recommendations and action plan from the MAPF will be prepared and circulated in draft format to be agreed by participants. Once completed, the report will be shared with the YOT Management Board.

The Report and agreed action plan will be owned and implemented by the Local Operational Group and shared with the regional MAPF Forum.

The YOT Service Manager will be responsible for ensuring any learning outcomes and recommendations are implemented within the service and that these are shared with staff members. Each partner agency involved in the review is responsible for implementing and sharing learning outcomes and recommendations within their own organisations.

6. Stages of the CSPPI



ANNEX 1

Ongoing Professional Practice

The management, assessment, reporting and oversight of serious incidents (safeguarding and public protection) are cited in a number of key documents which the YJS should take into account both strategically and operationally. These all remain relevant: -

All Wales Child Protection procedures 2008 (under review)

Welsh Government - Keeping Learners Safe (2015)

Standards for Children in the Youth Justice System – New National Standards (2019)

HMI Probation Youth Offending Services Inspection - Guidance Manual (2018)

YJB Case Management Guidance (2014) (including updated sections 2019)

Modern Youth Offending Partnerships (2013)

Social Services and Well-being (Wales) Act 2014 - Part 7 (Safeguarding)

Public Health Wales – Incident Reporting Procedure (2013)

Public Health Wales Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

In relation to *Serious Significant Incident Reporting in Custody*- HMPPS have guidelines in place for Governors and Directors of secure establishments. Following the reporting of an incident, local authorities may be engaged in these procedures by HMPSS, however there is not a separate set of requirements.

ANNEX 2

Terrorism related offence

A terrorist related offence covers those who have been convicted of:

- any offence under terrorist legislation
- an offence of conspiring, attempting, aiding, abetting, counselling, procuring or inciting an offence under terrorist legislation.

A terrorist related offence includes offences under terrorism legislation and other offences considered to be terrorism-related.

Terrorism is commonly defined as violent acts (or the threat of violent acts) intended to create fear (terror), perpetrated for an economic, religious, political, or ideological goal, and which deliberately target or disregard the safety of non-combatants (e.g., neutral military personnel or civilians).

Terrorism is defined in the Terrorism Act 2000 (TACT 2000) and means the use or threat of action where:

1. The action:

- a) involves serious violence against a person;
- b) involves serious damage to property;
- c) endangers a person's life, other than that of the person committing the action;
- d) creates a serious risk to the health or safety of the public or a section of the public, or
- e) is designed seriously to interfere with or seriously to disrupt an electronic system; **and**

2. the use or threat is designed to influence the government or to intimidate the public or a section of the public, **and**

3. the use or threat is made for the purpose of advancing a political, religious or ideological cause.

4. where the use or threat of action as defined above involves the use of firearms or explosives it is always terrorism, whether or not the condition in (2) above is satisfied.

ANNEX 3

Young person has sustained a potentially life threatening injury

A 'potentially life-threatening injury' is one that in the view of medical opinion there is a substantial risk of death.

The type of incidents which should be reported are:

All potentially life-threatening injuries sustained by a victim through the action of others for example:

- assaults involving offensive weapons, knives, bladed, pointed articles and other weapons (**all weapon inflicted injuries should be reported as 'potentially life-threatening'**)
- serious physical assaults (without weapons).

All potentially life-threatening injuries sustained by a young person which were caused by:

- misadventure – e.g. drug overdose, joy riding
- risk taking anti-social behaviour.
- self-harm

ANNEX 4

Young person has sustained serious and permanent impairment of health or development

The decision on whether a child or young person has sustained a permanent impairment of health or development will be defined by the clinical supervision team with medical responsibility. The medical team will identify if a substantial impairment of the function of a bodily member, organ, or mental faculty is likely to be permanent; or an obvious disfigurement that is likely to be permanent. This may be identified immediately at the time of the incident or may be defined a period of time after the incident occurred for example an injury to the head.

YOT should refer to their local Serious Case Review or Child Practice Review guidance for guidelines on defining a sustained or permanent impairment of health or development.

ANNEX 5

Guidelines on defining attempted suicide

An incident of 'attempted suicide' can be very difficult to identify, and risky self-harming behaviour where no intent to end life is apparent can be as dangerous as a concerted attempt at suicide. Defining these behaviours is not an exact science, but should be informed by assessments from health clinicians or local mental health professionals.

When considering whether a notification is required and whether there is learning to be gained from a case involving a suspected attempted suicide, practitioners and managers should consider past behaviours, the views of other professionals, the risk level of the young person involved, their thoughts and feelings (if it is possible to assess this at the point of notification) and the future risks of not reviewing the case.

ANNEX 6

MAPPA Serious Case Review (SCR)

The purpose of the MAPPA Serious Case Review (SCR) is to examine whether the MAPPA arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

The aims of the MAPPA SCR will be to establish whether there are lessons to be learned, to identify them clearly, to decide how they will be acted upon, and, as a result, to inform the future development of MAPPA policies and procedures in order to protect the public better. It may also identify areas of good practice.

The Strategic Management Board (SMB) must commission a MAPPA SCR if **both** of the following conditions apply:

- The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.
- The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

The report must not be widely distributed or published, and should only be shared with others on the authority of the SMB Chair. The timing of the report is crucial and its distribution may have to be delayed if it would have an adverse effect on any ongoing criminal proceedings. In cases of doubt, the SMB Chair should liaise with the Investigating Officer.

An Overview Report should be produced within one month of completion of the MAPPA SCR Report. The Overview Report should clearly identify which agency is responsible for delivering the Action Plan.