Mid & West Wales Youth Offending Teams (YOTs)
Policy & Procedures

Community Safeguarding and Serious Incidents (CSSI) Policy and Procedure
April 2023

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
V2	18/07/2025	Mid and West Wales Safeguarding Board	18/07/2023	18/07/2024
V3		Mid and West Wales Safeguarding Board	21/10/2025	21/1/2028

Name of Policy / Procedure / Guidance	Community Safeguarding and Serious Incidents (CSSI) Policy and Procedure April 2023
Consultation Period	10/05/2023 – 26/05/2023
Date of Publication	
Review Date	

Dissemination/ Implementation

Agencies are requested to undertake the following in order to ensure the implementation of this Policy/Procedure/Guidance

MAWWSB	• Place on MAWWSB website within policy section • Send to Partner Agencies for dissemination • Disseminate to partner agencies training leads for inclusion within training as appropriate • Update relevant training to reflect Policy/procedure/ guidance
All Partner Agencies	• Disseminate Policy/Procedure/Guidance to all Service Leads/ Heads of Service/Safeguarding leads/ staff via appropriate communication channels e.g., LOGs • Place within own website and include a link with MAWWSB Website https://www.cysur.wales/ • Update in-house Policies and Procedures to reflect Policy/Procedure/Guidance as appropriate. • Update in-house training to reflect process as appropriate.

Assurance

Agencies will be requested to undertake the following in order to assure the MAWWSB with regards to dissemination and implementation of this policy:

MAWWSB	• To seek assurance from Partner Agencies that implementation has occurred
Partner Agencies	• To provide MAWWSB with assurance that the above implementation has been completed

Contents

Community Safeguarding and Serious Incidents

1. Introduction

This guidance brings YJB Serious Incident Notification: standard operating procedures for youth justice services in England and Wales (March 2020) alongside regional safeguarding arrangements for YOTs.

Youth Justice Board Serious Incidents Notification

In 2021, the YJB reviewed how intelligence against serious incidents occurring in the community was gathered as part of its statutory responsibility for oversight. This highlighted that without a notification process of serious incidents in the community, the YJB has limited oversight of these serious events. This limits the effectiveness of timely and appropriate responses both locally and nationally, the deployment of practical support and, when required, ministerial liaison. It also limits collation of national data where a fuller picture of performance, trends, themes, and lessons learnt could be extracted.

Following a review of the voluntary notification procedure and consultation with the sector, the decision was taken to make Serious Incident notifications across England and Wales mandatory from the 1 April 2022 (As included within the terms and conditions of the Youth Justice core grant). Serious incidents notification: standard operating procedures for YJSs - GOV.UK (www.gov.uk)

Regional Safeguarding Arrangements

The above standard operating procedures **do not** replace any local, regional or national safeguarding requirements or policies. Indeed, decisions about whether/how to review incidents and relevant services being delivered to affected children are required to be taken locally, following multi-agency discussions, wherever appropriate.

The '**Learning and Review Framework'** has been developed with the intention that Regional Safeguarding Boards and their partner agencies provide an environment in which practitioners and their agencies can learn from their own and other's casework and from sources such as audits, research and inspection.

In the event of the following incidents, a referral for a Single Unified Safeguarding Review should be considered:

1. **Criteria for a Child Practice Review:**

Abuse or neglect of a child is known or suspected within the area of the Safeguarding Board, and –

a) the child has:

   i) died; or

   ii) sustained potentially life-threatening injury; or

   iii) sustained serious and permanent impairment of health or development.

2. A death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) a person to whom they are related or who they were or had been in an intimate personal relationship, or

b) a member of the same household. This includes where a victim took their own life (suicide) and the circumstances give rise to concern, for example they were suffering from domestic abuse.

NB: Where the subject of the Review has taken their own life, care needs to be taken to explore all opportunities to establish the chain of events and identify potential abuse, or perpetration that may have contributed to the decision.

3. A homicide is committed, and the alleged perpetrator has been in contact with primary, secondary, or tertiary Mental Health services within the last year.

Consideration of Single Unified Safeguarding Reviews is made by the Case Review Sub-Group of CYSUR.

However, for the purposes of the CSSI process, the majority of cases triggering this procedure will require the convening of a '***Multi-Agency Professional Forum***' (MAPF). The Single Unified Safeguarding Review Statutory Guidance (October 2024) describes the MAPF process as follows:

9.10 Multi-Agency Professional Forums (MAPFs) are a mechanism for producing organisational learning, improving the quality of work with families, and strengthening the ability of services to keep children and adults safe. In accordance with regulation 3(2)(i)57, Safeguarding Boards are required to arrange and facilitate an annual programme of MAPFs. They can be convened to explore learning opportunities in cases which do not meet the criteria for the completion of a SUSR. They utilise case information, findings from safeguarding audits, inspections, reviews, and other learning arising from the Wales Safeguarding Repository to develop and disseminate learning to improve local knowledge and practice, and to inform the Safeguarding Board's future audit and training priorities.

9.14 MAPFs have two main purposes:

a) Case learning: facilitated discussion, consultation and reflection by practitioners, managers, or core groups, using a systems approach to examining and analysing individual current or no longer active cases. These may include complex cases where there have been good outcomes, current cases that have become stuck, or cases which cause professional concern or interest that do not meet the criteria for a SUSR.
b) Dissemination of new knowledge and findings: from multi-agency safeguarding audits and from SUSRs, inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

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 subject to YOT prevention interventions/ Out of Court Disposals/Statutory Order) is involved (or is alleged to have been involved) in a safeguarding or serious incident, it is important that any evaluation of the related circumstances takes account 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 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 Serious Incident whilst under the supervision of or on the YOT caseload.

2. Identification and Local Notification of CSSI Incidents

The list of safeguarding incidents has been aligned with the requirements of Single Unified Safeguarding Reviews Statutory Guidance (Wales). It is the responsibility of the YOT Manager or Operational Manager to identify a Safeguarding or Serious 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 child/ young person is:

- Involved in a safeguarding incident while on the YOT caseload or up to 20 calendar days following the end of YOT supervision.

- Charged with committing one of the following serious incidents; this includes those children/young people not under the YOT supervision when they were charged;

The table below identifies the reportable incidents:

SAFEGUARDING INCIDENT	SERIOUS INCIDENT
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 while on the YJS caseload, or up to 20 calendar days following the end of YJS supervision (also applicable to YJB serious incidents notification)	**Murder/ manslaughter** (also applicable to YJB serious incidents notification)
Attempts suicide (informed by assessments from health clinicians or local mental health professionals) - **Annex 5**	**Rape** (also applicable to YJB serious incidents notification)
Is the victim of rape (where an allegation has been made to the police)	**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 - see Annex 2 (also applicable to YJB serious incidents notification)
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	**Grievous Bodily Harm (GBH) or wounding (Section 18 or 20).** Refer to YJB guidance on how this is determined.
Has sustained serious and permanent impairment of health and development - Annex 4	**Kidnapping/False Imprisonment or Child Abduction**
	Arson with Intent to Endanger Life

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 including referral via MARF to the Local Authority Child Care Assessment Team (CCAT).

Media Enquiries and Further Information

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).

3. Local Decision Making

Following notification of a CSSI by e-mail entitled ***'Urgent – Critical Safeguarding & Serious Incident'***, the Chair of the YOT Management Board, together with the responsible Head of Service for YOT, Head of Children's Services and Direction/Lead for Education Services, will decide if the incident requires a review of YOT practice or not; 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 e-mail, but the YOT Service Manager will attach the e-mail decision making record to the electronic case record.

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 policy framework.

Should a decision be reached that the incident requires review, the local Safeguarding Lead should be notified, and a Local Management Report (LMR) must be completed within 20 working days 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 report writer/lead reviewer and assist where necessary with the LMR. The LMR will be provided to the Chair of the YOT Management Board and the LA Safeguarding Lead. A decision is then required to determine if the matter should be referred in to the Case Review Sub Group for for consideration as to whether the criteria for a SUSR or MAPF are met. The LOG should be informed of the referral.
The Case Review Sub Group will, after considering the referral, make a recommendation as to whether a SUSR, MAPF or alternative process should take place. The final decision on whether to conduct a SUSR or MAPF will be made by the Regional Safeguarding Children's Board Chair, together with the relevant Community Safety Partnership Chair, if the case concerns a domestic abuse-related death.

It is anticipated that in most cases any wider learning will result in a MAPF at the local level. The MAPF process will be undertaken jointly by the agencies involved in the case, supported by the Regional Safeguarding Board, but the outcome must also be reported to the YOT Management Board and LOG. Where there has been a Critical Safeguarding Incident that would trigger an LMR and a SUSR is also being considered, the SUSR process would take precedence and the LMR would proceed but form the body of YOT evidence towards the SUSR.

On receipt of the Case Review Sub Group's recommendation in respect of the referral, the Chair of the Regional Safeguarding Children's Board may conclude that no additional review process (i.e. an SUSR or MAPF) is required in addition to the LMR. Should this be the case, the YOT case management records will be updated to reflect that the due process has been completed. It is recognised that approaches need to be proportional having taken account of the information provided by the YOT, that a 'lighter touch' review may be deemed to be appropriate.

Learning from the Child/Young Person and Parents/Carers

When reviewing incidents, it is important to give the child/young person, as well as their parents/carers 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.

Referral pathways and documents to be followed and completed as appropriate
1a Referral to Sub Group (Child).docx
1b Referral to Sub Group (Adult).docx

4. Multi Agency Professionals Forum (MAPF)

- A MAPF Chair will be appointed *(NB: if appropriate to the circumstances of the case, this will usually be the LMR author)* and a panel convened of representatives of the agencies involved in the case. The panel will produce a report identifying the good practice and areas of learning identified via the process, together with recommendations to support future practice improvements.

In attending the MAPF, each agency must ensure that they are represented by a senior officer independent of the case 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.

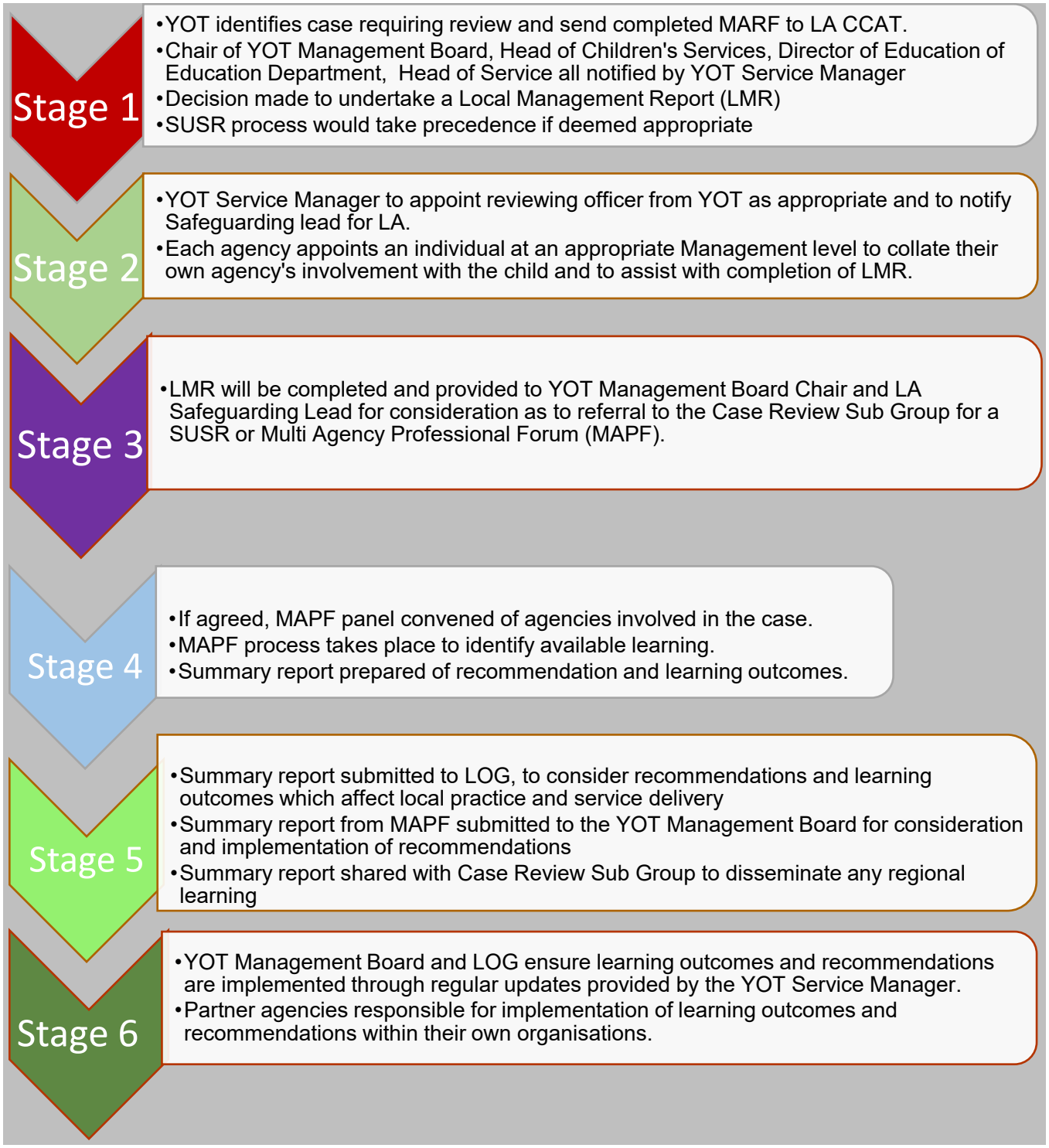
The output from the forum is intended to generate professional and organisational learning and promote improvement in future inter agency safeguarding and public protection practice.

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 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 Case Review Sub Group will also receive the completed report to facilitate the dissemination of any learning relevant to the Mid and West Wales region.

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 CSSI



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 YOTs should take into account both strategically and operationally. These all remain relevant: -

Wales Safeguarding Procedures (2019)

Welsh Government - Keeping Learners Safe (2022)

Standards for Children in the Youth Justice System (2019)

HMI Probation Youth Offending Services Inspection Guidance Manual (reviewed 2021)

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)

For clarity, if an incident takes place in custody, you should report it to the Youth Custody Service's Placement Team by calling its 24-hour telephone number 0345 36 36 36 3.

ANNEX 2

Terrorism related offence

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

1. The use or threat is designed to influence the government or to intimidate the public or a section of the public.
2. The use or threat is made for the purpose of advancing a political, religious or ideological cause, and
3. 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

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

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 5

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.