



MULTI AGENCY CHILDREN'S SAFEGUARDING AUDIT PACK EXAMPLE OVERVIEW REPORT



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REPORT TO LONTOWN SAFEGUARDING CHILDREN BOARD, SEPTEMBER 2009 MULTI AGENCY AUDIT OF 10 CASES OF CHILDREN SUBJECT TO A CHILD PROTECTION PLAN OVERVIEW REPORT

1. TERMS OF REFERENCE

This audit was undertaken by the Quality Sub-Group of the Local Safeguarding Children Board (LSCB), as part of a rolling programme as set out in the LSCB Business Plan 2009-2011. The terms of reference for the audit, as agreed with the LSCB in May 2009, are as follows:

'Ten cases of children subject to a child protection plan in May 2009 will be audited. The cases shall be selected to represent a spread of:

- Categories of abuse
- Ethnicity, age and gender mix
- A mix of professional and service involvements

The purpose of the audit is to identify areas of good practice and areas of concern to provide a baseline of performance. Emerging themes will provide a basis for further, more focused audit activity. There will be a clear focus on impact and outcomes, in line with the Ofsted full inspections of safeguarding and children in care, to assist with preparation for the inspections. An overview report containing recommendations will be prepared by an independent consultant. The Quality sub-group will turn these recommendations into a SMART* action plan, which will be ratified by the LSCB in September 2009, and implemented through the Quality Subgroup.'

2. METHODOLOGY

Ten cases, representing the mix described above, were selected in June 2009 by the Child Protection Conference Manager. Audits were conducted by auditors from each of the agencies who were working with the individual children and their families. Agencies involved in the audits covered a wide spectrum, including children's social care, health agencies, Child and Adolescent Mental Health Service (CAMHS), police, schools, children's centres, housing, adult mental health, drug and alcohol services, domestic violence services and voluntary sector organisations.

The cases were audited by managers who are experienced auditors, using a multi-agency audit tool with eight areas of questioning, designed to identify thematic strengths and weaknesses, as well as individual quality of work issues. Each section within the audit was graded individually, as well as an overall grade on each case, using the grading system from Ofsted inspections, as follows:

- 1 = outstanding (used as overall judgement only, if all categories good or better)
- 2 = good
- 3 = adequate
- 4 = inadequate

This system allows areas of good practice as well as areas of concern to be readily identified across agencies.

Judgement grades given by each of the auditors from different agencies auditing an individual case have been integrated to form one overall judgement for each area of work.

Any audits causing concern were referred immediately to managers for action. A copy of each audit has been returned to each practitioner and their manager so that they can respond to issues raised within the audit, or see that their good practice has been acknowledged.

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3. OVERVIEW OF EACH OF THE AREAS OF ANALYSIS

(Section 1 = Case details – no judgments needed)

Area of analysis 2: History of Involvement: - effectiveness of previous involvement?

Appropriate identification of Child Protection (CP) concerns and actions taken?



Previous agency involvement was adequate or good in eight of the ten cases. Previous involvement was mostly confined to single agency, universal provision such as school or health visitor routine post-birth involvement. In three cases, additional needs had been identified, but a Common Assessment Framework (CAF) had only been completed in one of these cases. In the other two cases, the school had made a referral to CAMHS services for one child, and the health visitor to a Children's Centre in the other. In both cases, a CAF would have been helpful to assess and plan more comprehensively.

Positive features included:

- Agencies were carrying out their required responsibilities as a single agency.
- Child protection concerns were identified appropriately in the majority of the cases, and a referral made to children's social care.
- Some practitioners sought advice within their agency about appropriate action (with some gaps).

The concerns in the two cases judged as inadequate were as follows:

- In one case, a school allowed a situation of neglect to continue without taking any action
- In the other case, a health visitor was aware of domestic violence within a family, and made an assessment about the physical risks to the child, but had not recognised the potential impact on the child in terms of emotional abuse.

Area of analysis 3: Referral: was referral appropriate or necessary? Was appropriate and timely action taken in response to the referral? Was a strategy discussion/meeting held as required?



Although appropriate procedures were followed in six of the cases, which ensured the child was made or kept safe, a variety of issues in four of the cases rendered them inadequate, and in two of those cases, this placed the child at risk.

Positive features:

- Three of the referrals were made at the appropriate time, contained all relevant information and were either made or followed up in writing/electronically. One of these was made on an eCaf (electronic Common Assessment Framework).

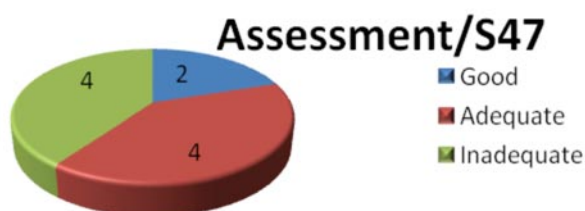
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- A further three referrals were made at an appropriate time, but the referral contained little or no contextual information about the child and family or the work already undertaken.
- The referral was acted on promptly by children's social care in nine of the ten cases.
- Strategy discussions with the police took place within 24 hours on nine of the ten cases.
- Cases were allocated to appropriately qualified and experienced social workers in all cases.

However, there were some significant concerns:

- The case relating to the young child suffering from the impact of domestic violence was not referred to children's social care by the health visitor. It was later referred by the Children's Centre when they became involved. The delay left the child potentially at risk.
- In one case, within a strategy discussion, the police Child Abuse Investigation Team (CAIT) manager agreed that the case warranted a joint investigation, but police were unable to undertake this due to resource issues.
- In another case, there was undue delay in responding to the social work manager's request for a strategy discussion by the police Sapphire team.
- In three cases, social workers did not inform referrers about the action taken on the referral.
- Strategy meetings were held in two cases. However, it would have been advisable to hold strategy meetings in a further three cases, to facilitate good information-sharing and planning of the S.47** investigation between a wider group of agencies.

Area of Analysis 4: Assessment/S47 Enquiry: Were appropriate actions taken to safeguard child? Were all checks made and agencies consulted? Was an interpreter used if needed? Were children seen alone and views sought? Were risks clearly evaluated? Has effective core assessment been completed?



Assessment was a variable area. Five of the families had been involved with children's social care previously, three on a child in need basis and two had previously been subject to a child protection plan. Complex family histories were not always fully taken into account.

Positive features included:

- Some of the assessments were of a high quality, identifying risk and needs comprehensively, enabling an effective plan to be made to improve outcomes for the child.
- Most assessments were clearly focused on the evaluation of risk and how the risks could be managed.
- Historical concerns were balanced with current concerns in some cases.
- In complex cases, the most urgent needs were highlighted and given priority.
- Assessments focused on the impact on the children (e.g. in domestic violence or other emotional abuse cases) in most cases.
- New concerns were generally taken into account.

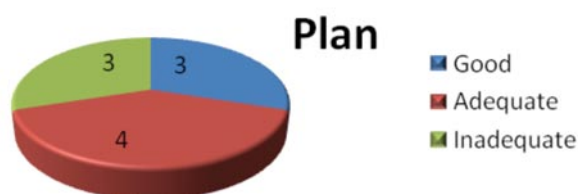
Areas of concern included:

- There were gaps in the assessment in two cases, e.g. mother's ability to parent, potential support from father's extended family.

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- In one case, the paediatric assessment lacked detail and did not assist in assessment of risk.
- It was not evident that children had been seen alone in two cases.
- Although it had been recorded that children were seen alone in a further two cases, the children's views were not evident in the S.47 enquiry.
- In two cases, the S47 enquiry was not further developed into a full assessment of the child's needs.
- The isolation of two of the young mothers, who had both arrived in this country recently, was not taken into account in the assessment.
- In one case, family members interpreted for the mother, not an interpreter, which may have hampered a full assessment.

Area of analysis 5: Planning and Implementing Plan: Was conference convened promptly? Was conference effective? Is there a consensus about risk? Is core group working effectively? Are appropriate resources in place? Are all agencies carrying out their responsibilities? Is the child visited regularly? Is there an appropriate response to further critical incidents?



Outline plans made at case conferences was generally a strong area. In general, child protection plans are focused on reducing risk; they set out what needs to happen in practical ways, they spell out the consequences if risk is not reduced; there are clear timescales and there is a focus on the children's welfare as well as safeguarding needs. Where auditors have highlighted concerns, they generally relate to the implementation of the plan, rather than the robustness of the plan itself.

Conference chairs ensured that any differences in views, relating to risk or other areas, were raised and explored at conference. Evidence of some differing views in a minority of cases can be perceived positively, as it shows an attitude of healthy challenge between agencies.

The effectiveness of core group working is of significant concern. In some cases, detail was added to the plan within the initial core group and confirmed by a written agreement with parent(s). However, following the initial core group meeting, subsequent core groups in the majority of the cases did not meet at regular intervals and when meetings were held, there were gaps in attendance from various agencies or services. This had an adverse impact on the implementation of the plan and in one case, poor information-sharing heightened the risk to a child.

Visiting frequency by social workers is cause for some concern. The usual visiting frequency set by the plan is two-weekly and in most cases social workers kept to this pattern, with a mix of announced and unannounced visits. Where concerns have been indicated, this often relates to the parent(s)' lack of compliance with the child protection plan, but in other cases there are some unexplained gaps in visiting. There is some evidence that social workers try to build constructive relationships with parents, although this is not always possible. There appears to be individual variation between social workers about direct engagement with children, but most record their observations of the children's behaviour and interaction with parents.

Other positive features included:

- Reassessment of risk at a case conference ensured care proceedings were instituted at an appropriate time.
- Arrangements were made to see older children at school when the parent had resisted visits at home.
- There were three examples of good multi-agency working, with effective core groups, a "team around a child" approach and good information-sharing, which contributed to keeping the children safe.

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Areas of concern included:

- In one case, the mental health social worker for the mother did not appear to recognise the concerns for the child's welfare and did not share information, which put the child at risk.
- In some cases, visiting was generally in line with the plan, but with some gaps.
- In some cases, children were not seen alone regularly.
- Agencies generally carried out their responsibilities and implemented the aspects of the child protection plan for which they had responsibility. However, this was not always achieved within the timescales set by the plan.
- The resistance of some parents to engaging with agencies in implementing the child protection plan not only slowed down the implementation of the plan but had an adverse impact on children's safety in two cases.

Area of Analysis 6: Review: Are review conferences held within timescales? Are review conferences effective in assessing implementation, progress, outcomes for child, risk, partnership working with parent(s); parent(s) understanding and in amending the plan to make it more effective.



All review conferences in the sample were held within required timescales.

However, there are serious concerns relating to this area of work, concerning the frequent lack of progress in the implementation of the plan, partly at least due to the poor core group working cited above. There also appears to be some tacit acceptance of the ineffectiveness of core group work and that this state of affairs has become the norm.

Positive features in this area:

- Child protection conference chairs ensured the level of risk to the child was reviewed at each conference and that a recommendation was made about appropriate action.

Areas of concern:

- Areas of poor performance by agencies in implementation of plans were not consistently raised as a quality assurance issue by the child protection chairs.
- There were gaps in attendance at review conferences, particularly of school staff.

Area of analysis 7: Management and Supervision: Are front-line practitioners appropriately supported and directed? Are social workers regularly supervised, is supervision of good quality, including analysis of risk, evaluation of progress, supervision decisions recorded and supervisor present at key meetings? Is there evidence of consultation with senior managers?



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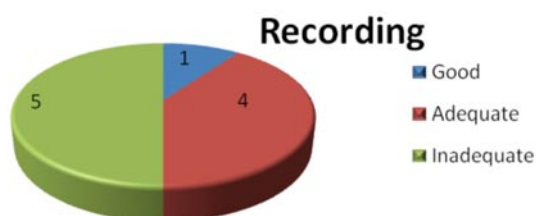
Agencies other than children's social care generally had less access to formal supervision, although there was some good practice in some health visitor teams and the police CAIT team. Other staff, such as teachers or voluntary sector providers were able to seek formal consultation within their management structure when needed.

There was some variation in management oversight within children's social care. Where practice was good, features included regular supervision, good progression of the plan, reassessment of risk, use of consultation with child protection chairs and others, consultation with more senior managers on cases causing concern. These cases were described as well-managed, and supervision of good quality. Managers were also present at conferences, and occasionally made joint visits, but did not consistently chair the initial core group as required. However, where there were failings or gaps in management oversight, this had potentially serious implications for the safeguarding of the children.

Specific concerns in this area of work:

- Some voluntary sector practitioners were not receiving adequate support and direction within their service.
- Although one health visitor team received good support and direction, this was not consistently provided in the other two teams.
- Where social workers did not receive regular formal supervision, there was generally access to informal consultation. However, the lack of formal supervision meant there was less opportunity for reflective practice, or assessment of progress, which had an adverse effect on children's welfare.
- Managers did not appear to give guidance during supervision on key issues such as direct engagement with children; how to deal with parental resistance; or how long a family support model should remain in place.

Area of analysis 8: Recording and Minutes: Are CP conference and core group minutes distributed promptly? Are all records for the child up-to-date fit for purpose and do they meet all requirements? Is there evidence of file audit or other quality assurance measures?



Child Protection conference minutes were distributed promptly and reliably. However, even when core group meetings were held (see comments in Areas of Analysis 5 and 6); participants rarely received any written record of the core group meeting. This led to some delay in implementing a plan. The most significant concern is that it meant that there was a lack of information-sharing with core group members who had sent apologies or not attended, which potentially affected the safeguarding of the children.

Case recording was generally a positive area. Recording across agencies was up-to-date and fit for purpose. Best practice recording in social work records was up-to-date, focused on key issues such as observations of the child and work undertaken to progress the plan; differentiated between siblings and demonstrated the quality of the practice.

However, there was a lack of evidence of file audit. An audit of records took place on transfer from the social work duty team to the longer-term teams. Apart from this, there is little evidence of file audit across agencies.

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The concerns in this area of work, in addition to those highlighted above, relate mainly to consistency of practice:

- Chronologies were not consistently in place on social work files.
- Some records were not child-specific and records were pasted across to siblings.
- Some health and school records were hand-written, and some were quite difficult to read.

4. CONCLUSIONS

This audit has identified some key issues which need to be addressed. Although practice generally keeps children safe, there is some individual variation in practice which has the potential to put children at risk. The key area of poor practice is core group working. Improving this would have a big impact timely and effective implementation of child protection plans and thus overall improvements to safeguarding children and promoting their welfare. Although any audit is bound to highlight areas of concern, auditors were asked to make general comments at the end of the audit form and many took the opportunity to comment on good practice and high level of commitment from practitioners.



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5. RECOMMENDATIONS

1. Findings from this audit should be cascaded by managers to the staff group so that issues affecting the individual team can be acted upon and clear direction given about accepted standards of practice and compliance with procedures, including attendance at review conferences and core groups and visiting requirements.
2. The LSCB should ensure that managers identify the training needs of the staff they manage and ensure their needs are met; in particular to deal with some of the issues identified through this audit. This includes:
 - Child protection, knowledge of procedures and skill development in identification of child protection concerns; understanding the impact of abuse and neglect; assessment; direct work with children; working with resistant families.
 - CAF training should be rolled out more widely and the profile of this way of working, raised.
3. Good practice in strategy discussions and meetings should be identified and shared with agency managers. This area of work would benefit from re-audit in six months time.
4. The independent chair of the LSCB should discuss whether resourcing issues are affecting adherence to Working Together requirements with police representatives.
5. Core group working must be improved. Particular attention should be given to:
 - Ensuring core group working is prioritised across agencies.
 - Good practice in core group working should be developed and disseminated to staff groups.
 - Chairing arrangements for core groups by social work managers.
 - Requiring practitioners to take up non-attendance or lack of record of meeting through their management line.
 - Raising the profile of the quality assurance role of the child protection conference chairs so that any gaps in core group meetings, or lack of effectiveness in implementing plan in a timely way, are followed up by managers.
 - There should be a re-audit of this area of work in 6 months time, with a wider sample.
6. Social work managers should ensure social workers visit families in accordance with the plan and that children are seen alone, as part of their management oversight role.
7. The social care supervision policy should be reviewed to ensure it is fit for purpose and requirements reinforced with supervisors of staff.
8. The Quality sub-group of the LSCB should draw up a quality assurance framework which would include routine management audits of individual files across agencies.

Jo Bloggs
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December 2009

* SMART is an acronym for Specific Measurable Agreed Realistic Timely.

** S47 – Section 47 of the Children Act 1989 places a duty on Local Authorities to investigate when there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

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