# Gloucestershire Safeguarding Children Board Bulletin:

# Keeping Children and Young People Safe

## Highlighting Lessons from a Strategy Discussion Audit

### What is the Purpose of this Learning Sheet?

In June 2015, the GSCB Quality Assurance Sub Group did an audit on a sample of Strategy Discussions. It took an intensive look at six cases, using them as a 'window' into the wider safeguarding system. 2 cases were judged to be Good, 3 required improvement and 1 was found to be inadequate. The purpose of this Bulletin is to inform any professional who attends a Strategy Discussion about areas for improvement in Gloucestershire and top tips towards best practice – whether you have been invited for the first time, or you often attend, or if you Chair the meetings. The learning on the following pages can be used to support reflective discussion in individual or group safeguarding practice reflection.

### Recap: What is a Strategy Discussion?

Strategy Discussions are about planning action and investigation in order to make sure a child is safe.

When information is gathered during a referral or as part of an assessment and results in concerns that a child is suffering or likely to suffer significant harm, the local authority should hold a Strategy Discussion.

**Additionally, anyone can request a Strategy Discussion.**

The purpose is to decide, with other agencies, whether to initiate enquiries under section 47 of the Children Act 1989.

### After reading this, where can I find out more?

First have a look at the learning from these cases, as a 'window into the system', to reflect on just how important Strategy Discussions are when shaping decisions about a child's safety – then if there is anything you want to check about the process there are 3 useful places to go:

- **Working Together to Safeguard Children - Flowchart (page 38)**
- **South West CP Procedures**
- **GSCB Website: Safeguarding standards and guidance**

**Outline - The Cases Sampled**

**What:** Strategy Discussions can take the form of a multi-agency meeting, or telephone calls. In the cases sampled, 5 out of 6 were meetings. The remaining case was a telephone strategy discussion followed by a joint visit (Social Care & Police) to the family home.

**When:** A strategy discussion can take place following a referral or at any other time, including during the assessment process. The cases sampled included a range of timings, where some Strategy Discussions were triggered by a specific incident and some an accumulation of concerns.

**Why:** examples included;

- A referral from the Sex Offender Unit, after a sex offender had been released from prison and made contact with the children via their mother
- A case of suspected Child Sexual Exploitation, after an Initial Assessment of Need gave reasonable cause for concern about significant harm
- A case already open to a Targeted Support Team, with escalated concerns about Domestic Abuse
- A child presented with a fractured skull to Gloucester Royal Hospital, who contacted the Social Care Emergency Duty Team.

| A) Attendance: What we looked for | Summary of Findings | Lessons & Practice Pointers |
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| • Whether a social worker, their manager, a police representative and a health professional, as a minimum had been involved in the Strategy Discussion.<br><br>• Whether other relevant professionals took part, depending on the nature of the individual case.<br><br>• Whether attendees were sufficiently senior to make decisions on behalf of their agencies. | In all 6 cases, the Strategy Discussion was attended by a Social Worker, a Social Care Manager and a police representative, usually a Detective Sergeant. In all 6 cases the attendees were found to be sufficiently senior to make decisions on behalf of their agencies.<br><br>The police representative was not always of a senior rank. However, specific to the case they were well placed to make authorised decisions on behalf of the police; for example an experienced Police Constable working for the Child Sexual Exploitation Team.<br><br>In all but one case there was representation from health professionals. For example a School nurse, Paediatrician, Health Visitor, Hospital Staff Nurse or a combination of these.<br><br>In the case where this was missing it was clear that the School Nurse, who was quite involved with the child, should have been involved.<br><br>In all 6 cases, other professionals took part as appropriate. This included a Family Support Worker;<br>Community Nursing Team representative; Probation Officer; School Designated Safeguarding Lead; Youth Support Worker; SEN Coordinator; Lawyer. | **The learning from this audit is:**<br>• Attendance is largely appropriate, but;<br>• We need to make sure that health representatives are always included; they have an essential role to play.<br><br>**We know from Serious Case Reviews that:** the absence of health professionals can make a critical difference, leading to information being missed from the discussion. For example:<br>• if no-one present has met the child or can give their perspective (Victoria Climbié),<br>• if key medical staff are not present, and<br>• omitting a Paediatrician from the strategy discussion where they have valuable information to contribute (Baby F, Bexley 2014)<br><br>**The South West Child Protection Procedures** provides a useful checklist of other relevant professionals that may need to be included. It reminds us that best practice is all agencies involved with the child/family to be involved in a strategy discussion, and that any delay that this may cause must however be weighed against the risk to the child and the possible need for the police to gather forensic evidence.<br><br>**Together we can ensure best practice if**<br><br>• Social Care ensures in each case that they check who needs to be invited from a health perspective;<br><br>• the Police question if this is not the case;<br><br>• health representatives challenge through the GSCB Escalation Protocol if they are ever omitted from the meeting<br><br>• For school age children the school nurses need to be involved and for pre school children the health visitor needs to be involved<br><br>• The school nurse does not represent the school, the school should be invited too and be expected to attend<br><br>***It is worth knowing that:*** *Health Visitors and School Nurses can be contacted through a team email address which is monitored daily and that if no response is received from the team, the request can be escalated to the Safeguarding Nurses.* |

| B) Timeliness: What We Looked For | Summary of Findings | Lessons & Practice Pointers |
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| • Whether the Strategy Discussions were held within a timescale which appropriately reflected the urgency of the cases. | In three cases we found the Strategy Discussion had been held within an appropriate timescale (for example the same day, or appropriate safeguarding work done before the meeting, or in the case of a child in hospital, making a well reasoned judgement call to prioritise the focus on getting the right people to the Strategy Discussion to inform decisions about whether or how he returned home).<br><br>In two cases, the timing of the Strategy Discussion was not found to reflect the risks in the case and although at the time of audit the two children were deemed to be safe, the rationale for not holding the Strategy Discussion sooner had not been made clear in the records.<br><br>In the remaining case, auditors had a difference of views. The majority were of the view that the Strategy Discussion timescale had been appropriate because the risks to the child had been removed during the father's bail conditions and some sterling work by Gloucestershire Domestic Abuse Support Service (GDASS). Some auditors felt however that the Strategy Discussion should have been held regardless of bail conditions, to prevent the risk of the case becoming incident led. | **The learning from this audit is:**<br>• The majority of cases evidenced timely Strategy Discussions, but<br>• the GSCB cannot yet be assured that this is consistently the case.<br><br>**We know from Serious Case Reviews that:** Delays in convening the formal Strategy Discussion in a timely manner, instead holding a series of multi agency discussions or conversations, can hamper ensuing Child Protection enquiries. For example:<br>• Child 'Julia', Thurrock 2014 & Baby T, Gateshead, 2014<br>• Local Serious Case Review, (Child 'Kevin', Gloucestershire, 2009) reminds us of the impact if there is any confusion about the timing of a Strategy Discussion.<br>• A later Serious Case Review (Child 'Abigail', Gloucestershire, 2014) found that a better understanding across agencies now exists of when the threshold for a Strategy Discussion is met as opposed to a multi-agency meeting without the status and purpose of a Strategy Discussion, but it is important to retain this understanding to increase the consistency of evidence of timeliness.<br><br>**The South West Child Protection Procedures** provide guidance about Strategy Discussions taking place as soon as possible where there is information that suggests that a child is at risk of significant harm.<br><br>The SWCPP remind us that only in exceptional circumstances, where delay may mean that child is put at increased risk should action be taken without a strategy discussion being held – in these situations a strategy discussion must take place within 24 hours<br><br>**Together we can ensure best practice if**<br><br>• senior managers support the knowledge and conditions for timely Strategy Discussions; and<br><br>• if all Strategy Discussion attendees check that the ensuing record of the meeting is very clear about the rationale and reasons behind the timing of the meeting. |

| C) Discussion: What We Looked For | Summary of Findings | Lessons & Practice Pointers |
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| • Whether the Strategy Discussions considered the children's welfare and safety using available information to identify the level of risk faced by the child. | In three cases this was found to be so. There were good examples of considering the child's perspective, risk to siblings, taking account of previous history, leading to balanced decisions about whether (for example) injuries were consistent with the explanation given or what protective actions were required next.<br><br>In 2 cases this was not found. There was insufficient coherent analysis of risk.<br><br>In 1 case this was simply not evidenced and hard to tell from the record. Nothing was recorded to show previous history was evaluated during the meeting, and the risk level was not explicit.<br><br>In the case of the father who had come out of prison after committing sex offences, the focus of the Strategy discussion appeared to be on the mother's protectiveness rather than explicitly the level of risk to the child.<br><br>It was not clear in a number of agency records, particularly health agencies that they had attended a Strategy Discussion as opposed to "Meeting with Social Care". | **The learning from this audit is:** It is important to be clear about the purpose and the legal framework for a Strategy Discussion for example:<br>• professionals coming to the meeting with relevant information and chronologies held by their agencies;<br>• the chair enabling the sharing of that information in a way that is proportionate, relevant and leading clearly to explicit statements about the child's welfare, safety and level of risk.<br><br>**We know from Serious Case Reviews that:** if the expected practice in relation to strategy discussions has not been followed, the information that exists may not be shared and discussed to the extent that risks are properly evaluated particularly if;<br>• all the evidence held by the agencies fails to be drawn together and evaluated<br>• Keanu Williams, Birmingham, 2013; Child G, East Sussex 2013.<br>,<br>**The South West Child Protection Procedures** emphasise the importance of making sure the discussion explicitly identifies the level of risk faced by the child; of the police discussing the basis for any criminal investigation and any relevant processes that other agencies might need to know about, including the timing and methods of evidence gathering; and deciding whether enquiries under section 47 of the Children Act 1989 should be undertaken.<br><br>**Together we can ensure best practice if**:<br>• the Chair of the Strategy Discussion uses the 'script' provided, which acts as a reminder of the purpose of the meeting, the legal framework, the areas to discuss and the responsibilities of attendees.<br>• Non-social care professionals also need to make sure they record 'Attended Strategy Discussion' in the case file rather than 'Attended meeting at social care'. |

| D) Decisions:<br>What We Looked For | Summary of Findings | Lessons & Practice Pointers |
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| • Whether the focus of the meeting was making a decision about grounds to initiate an enquiry under section 47 of the Children Act, what further information will be gathered if an assessment is already underway, what immediate and short term action is required to support the child, and who will do what by when.<br><br>• Whether decisions about what information should be shared with the child and family were checked; (On the basis that information is not shared if this may jeopardise a police investigation or place the child at risk of significant harm).<br><br>• Whether the record of agreed decisions was in accordance with local recording procedures. | The focus of the meeting on deciding whether or not to undertake section 47 enquiries, which is the main purpose of a Strategy Discussion, was clear in only one case. It was thought likely that this reflects poor recording rather than poor decision making. Several records did appear to imply a focus on whether to call an Initial Child Protection Conference or not, which is not the purpose of a Strategy Discussion. We commended a particularly good example of a Chair providing healthy challenge to the focus of the meeting, which appeared to be about convening a Child Protection Conference.<br><br>In all 6 cases there was good focus on decisions about *follow up action*, for example whether or not to speak to the child, initiate a medical examination, criminal proceedings, or legal action. Good practice on decisions about legal action included a) response to a breach of a Sexual Offences Prevention Order and b) instigating a Harbourers Warning. Good examples of protective actions included providing respite care; provision of GDASS support; joint visits with a clear purpose. There was a tendency however to talk in terms of services rather than need and risk reduction. | **The learning from this audit is:**<br>• we do not always keep the clarity on the purpose of the meeting being to decide whether section 47 enquiries should be initiated; however,<br>• the focus is very good on information sharing and deciding protective actions.<br>• It is important to remember that at the end of the meeting when the multi-agency plan of action is drawn up, part of this may be to convene an Initial Child Protection Case Conference but this is not the central purpose.<br><br>**We know from Serious Case Reviews that:**<br>• It is vital that actions agreed during the Strategy Discussion are allocated to specific people, with a date for completion, otherwise<br>• the meeting will be unclear about who should deal with the actions or questions identified for a Section 47 enquiry, no timescales will be set and subsequently the actions may not be completed (Victoria Climbié).<br><br>**The South West Child Protection Procedures** provide a helpful checklist in line with Working Together 2015, about the key decisions that the Strategy Discussion needs to consider. It also provides a thought provoking question; Think about pressure from high-status referrers or the press, expressing fears that a child may die, may lead to overzealous action.<br><br>***Ask yourself: Would I see this referral as a serious protection matter if it came from another source?***<br><br>**Together we can ensure best practice if:**<br><br>• Senior Managers who supervise staff within their agencies, and relevant GSCB Trainers, are absolutely clear that the central outcome of a strategy discussion is to plan a S.47 investigation; and<br><br>• that the Chair of the meeting checks that the rationale behind the meeting outcomes is clearly explained in the record of the meeting. |