Child Protection Audit 2015/16

Gloucestershire Safeguarding Children Board

What did we do?

A range of professionals from different settings joined the **Multi Agency Quality Assurance Sub Group** to audit the quality of work and impact for **29 children who were subject of Child Protection Plans.**

Audit questions focussed on

- **the identification of risk**
- **thresholds for intervention**
- **the planning process and the Child Protection Plan**
- **risk management**
- **the quality of practice**

The **impact** of practice was then examined through a 'distance travelled' scale, used to measure levels of risk at the time of the Initial Child Protection Conference compared to the time of audit.

What did we find?

Three cases were good overall, with some outstanding elements. These cases showed consistent good practice across all audit domains, creativity and evidence of solid relationship-based practice, with the voice of the child coming across strongly, and significant or demonstrable impact for the child.

17 cases were found adequate overall, showing satisfactory practice across all audit domains, with some inconsistencies but in most areas, clear explanations for limits to practice.

No children were found to be unsafe during the audit resulting in immediate auditor intervention, but **9 cases were found inadequate in quality of practice** due to overall lack of clarity of focus. This included for example risk analysis, a robust plan, and limited impact (at the time of audit) on better outcomes.

Identifying Risk - Top 5 Findings

1. Good and Adequate work demonstrated appropriate **multi agency presence and engagement** in information sharing about strengths and risks, in person and/or through agency reports to the Child Protection Conference.
2. These cases also showed **strengths and risks in the child's situation were clearly set out** in the combined Section 47 enquiry and reports.
3. There was evidence of the **child's experience, wishes and feelings** being taken into account.
4. These cases also showed Child Protection Conference records

Thresholds for Intervention - Top 5 Findings

1. Good and Adequate work demonstrated professionals judgements focussed on **evidence** of significant harm or its' likelihood, **substantiated** by the findings of enquiries and research evidence, **balancing risks and strengths**.
2. These cases also showed children **considered separately** as well as together in terms of the family context as a whole
3. Auditors saw **appropriate decision making** in these cases, as to whether or not the child was made subject of a Child Protection Plan or the Plan was discontinued.
4. Where the child was not made subject of a Child Protection Plan, there

evidencing **multi-agency analysis of risk**.

5. However, 2 cases were **inadequate in the sufficient involvement of all appropriate agencies**, or **limited focus on the child's experience**, and the combined records **did not clearly evidence analysis of risk.**

was **due consideration of what needed to happen next** through either Early Help or a Child in Need Plan.

5. However, 7 cases were **inadequate in the clarity of the rationale** for levels of intervention. Three of the children could arguably have been worked with as Children in Need. In four cases the child was correctly not made subject of a Child Protection Plan but there was **insufficient consideration of how Child in Need work would be achieved.**

Child Protection Planning - Top 5 Findings

1. Good and Adequate work demonstrated that the Core Group had **developed the Outline Child Protection Plan** after the Conference. This strengthened clarity about what needed to change, within what timescales, what support would be provided, and what would happen if things did not improve within the child's timescales
2. These cases also showed an **appropriate range of partners** involved in the planning, relevant to the assessed need.
3. Where appropriate, the **child had been involved** in putting together or informing the plan for risk reduction or prevention
4. There was evidence of **appropriate local services** within the plan, tailored to individual need, with agreement on who is accountable
5. However, 10 cases were found **inadequate in terms of developing the Outline Plan**, with questions raised about focus and tailored intervention. In 5 applicable cases the records across agencies did not give assurance of the **child being engaged** clearly in the plan.

Risk Management & Review - Top 5 Findings

1. Good and Adequate work demonstrated a **clear focus on the extent to which the plan was meeting the needs of the child**, demonstrated in Core Group meetings and the Review conference, with **agreed agency actions being carried out** in line with the plan
2. These cases also showed a range of **positive impact** on preventing, reducing or managing risk.
3. Another feature was **children being engaged** in such a way as to make sure the review of whether the plan was working, was informed by their views or experiences.
4. There was also **increased evidence of appropriate and effective challenge** than seen in previous audit, if outcomes were not secured.
5. However, 9 cases were found **inadequate in the Core Group's focus on the impact of the plan**, to continue or adjust it. Records of discussion appeared to show the focus was **updates on actions or incidents, rather than evaluation of progress and impact**. 3 cases did not show **appropriate challenge** between Conferences where there was drift.

Strengths in Practice - Top 3 Findings	Areas for Improvement - Top 3 Findings
Auditors recognise there will be exceptions within the full cohort of Child Protection Cases, but as 'windows' into the system, the 29 cases indicated general thematic strengths as follows; 1. **Appropriate decision making** in terms of whether a child should be made subject of (or remain subject of) a CP Plan 2. **Appropriate and sufficient identification of the risks**, as evidenced in Child Protection Conference records 3. Discussion at CP conferences showing **professional judgements focussed on evidence of harm, substantiated by findings of enquiries, research evidence, and review of progress**.	The 29 cases also indicated general thematic areas for improvement; 1. Core Groups need to **develop the Outline Plan** between Conferences 2. More Core Groups need to **involve the child** in making the Plan itself 3. Too many Core Groups **struggle to secure impact** on reducing risk. A recurring challenge was the **mixed picture of effective co-ordination.** The large number of agencies involved in some cases inadvertently leads to difficulties for the Core Group to understand who is doing what, with what impact. For example in one case, 8 separate services were helping. Continuity was also a problem: workers dipping in and out of Core Groups does not help.

Impact - Top 6 Findings

1. **Significant improvement** was found in the lives of two children. These cases demonstrated high quality relationship-based practice.

2. **Some improvement** (with some areas still to work on) for 17 children. These cases demonstrated persistence.

3. There appeared to have been **no progress** for 7 children. Not all of these cases demonstrated poor practice, some were beset by non engagement or disguised compliance and many were considering or initiating legal proceedings.

4. **Risks appeared to be higher** for three siblings. Auditors recognised in this case it could be that the risks were simply being better understood over time.

5. **Where impact was limited** the nature of the cases had recurring themes; children's circumstances commonly included parental substance abuse; domestic abuse; parents separating and uniting with new partners of concern; lack of sustained change; and adolescent risk taking behaviour.

6. **Uncertainty whether positive change would be sustained** led in some cases to extended timescales**.** It is sometimes difficult for practitioners to either remove a child from a CP Plan or to escalate to care proceedings b ecause of uncertainty about sustained change. This sometimes leads inadvertently to an adult focus to the detriment of the child's timescales .

Top 5 Tips for Practice

1. **Core Groups - Good communication includes taking stock and thinking ahead.** Are you considering great **tools like MOMO** (an app that children and young people engage really well with) to involve the child at each key point? Think ahead if the child will be starting a new school, **contact the Designated Safeguarding Lead** *before* the summer holiday to inform them of concerns. **Keep taking stock of your Core Group membership** at each meeting if there are lots of agencies are involved, this needs to be kept constantly under review. Not doing so can lead to a false sense of security, layering or duplication of services without clarity of impact, or key practitioners inadvertently being left out.

2. **Practitioners -** remember to suggest a **professionals meetings** if you think things are getting stuck**.** Where professionals were able to have a professionals meeting this had a positive impact on the cohesiveness of the core group and sense of clear direction. Participation of children, young people and families is still a priority, but not to the exclusion of opportunities for shared, reflective, professionals discussion and planning. A **Reflective Model for Professional Meetings** is available, endorsed by the GSCB. Social Care Team Managers are required to hold professional meetings on any child who remains subject of a Child Protection (CP) plan for more than 12 months. Auditors cold see that **where there was reflective practice and healthy challenge, things moved forward.** There were increased signs of the *"Escalation Policy"* actively being used, but do remember to keep working together in a way that brings each other both high support and high challenge.

3. **Safeguarding Partners - ensure continued promotion of the agreed escalation policy.** All agencies should make sure that core groups use it, as a way of engaging in healthy challenge where they have concerns. CP Conference chairs are well placed to support. **Communicate that the CP plan is only a start and not an end point.** CP Conference Chairs can support Core Group members clarity on this.

4. **Child Protection Chairs -** continue to support the expectation that if a Child is not/no longer to be subject of a Child Protection Plan, the Child in Need Plan will be discussed and set out with your assistance before the Conference concludes.

5. **All partners -** whether part of a Core Group or a Strategic Lead - raise awareness about or take part in the **GSCB Child Protection Reflective Learning Circle** which is hosted by the GSCB and chaired by the Head of Quality. Its purpose is to support reflective practice to safeguard children in complex, stuck or 'repeat' cases. The Core Group provide a brief written reflection beforehand about the child's circumstances, views from the core group about effectiveness and barriers to effecting sustainable change, and a multi agency panel joins them to reflect on specific issues that the group invite the panel to assist with.