Cheshire East Local
Safeguarding Children Board

Multi-Agency Case Audit Report

Into Repeat Child Protection Plans.

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February 2014.

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Section 1: INTRODUCTION

1.1 Terms of reference

1.1.1 Working Together 2013[1] requires Local Safeguarding Childrens Boards (LSCBs) to fulfil their statutory objectives and functions as set out in section 14 of the Children Act 2004[2] and Regulation 5 of the Local Safeguarding Children Boards Regulations 2006[3].

1.1.2 One LSCB function is to ensure the effectiveness of the member agencies practice by quality assuring practice, including through joint audits of case files involving practitioners and identifying lessons to be learned (page 60, paragraph 2).

1.1.3 This audit was undertaken by Cheshire East Safeguarding Children Board (CESCB) Quality Assurance Activity, as part of a rolling programme of multi-agency audits, as set out in the Children's Improvement Board - Quality Assurance Framework.

1.1.4 The terms of reference for the multi-agency audit, as agreed with the CESCB in August 2013, are as follows:

- Bi-monthly audit with an alternate emphasis on quantitative and qualitative information through audits of 8 and 20 - 25 cases.
- The cases shall be selected to represent a theme as confirmed by CESCB Executive Group on the basis of knowledge of CESCB priorities and performance data.
- Engagement of practitioners directly involved, and with children and their families where possible and appropriate.
- Audit reports will be provided to the LSCB Executive Group and Children's Improvement Board.

1.1.5 The purpose of the audit is to identify areas of good practice and areas of improvement and to identify learning for development in the safeguarding of children. There is a clear focus on the impact and outcome of multi-agency working. The emerging themes will provide a basis for further more focussed activity.

1.1.6 Workshops for audit leads and practitioners to learn and develop from the audit findings have been built into the process. The views of families/parents are obtained during the process.

1.1.7 An audit report containing the findings will be prepared by an Independent Audit Lead commissioned by CESCB. The report and findings will be received by the CESCB Executive Group in March 2014. The CESCB will respond to these findings and develop a CESCB Response to Audit Findings Action Plan, to be implemented through the CESCB Executive Group.

[1] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, (2010), March 2013.
[2] Children Act 2004
[3] Local Safeguarding Children Boards Regulations, 2006.

Section 2: AUDIT METHODOLOGY

2.1.1 The focus of a CESCB multi-agency case audit programme is on multi-agency professional practice, highlighting good practice as well as identifying improvements which need to be made to local services. The principles for learning and improvement identified in Working Together 2013[4] were followed by the multi-agency audit leads conducting this audit.

2.1.2 The CESCB commissioned an Independent Audit Lead, Valerie Charles, to lead on the multi-agency case audit programme.

2.1.3 This multi-agency audit was undertaken during January 2014 and February 2014, under the theme of 'repeat Child Protection Plans' and involved a sample of 15 child protection cases where a child is subject to a repeat Child Protection Plan.

2.1.4 On 16th January 2014 a report was generated by the PARIS electronic case management system, identifying all the current child protection cases where a repeat Child Protection Plan was in place.

2.1.5 The report identified that Cheshire East had 202 cases with a Child Protection Plan, of which 34 Child Protection Plans (16%) are repeat Child Protection Plans. These 34 plans included: seven sibling groups; twenty three Child Protection Plans in the category of neglect and the remaining eleven were in the category of emotional abuse; and the interval between plans ranged between 6 months and 10 years.

2.1.6 The Business Manager of CESCB, in consultation with members of the LSCB Executive Group, selected a sample of 15 cases where the period of time between Child Protection Plans was 3 years or less and also chose one child from each sibling group. There was a balance of gender, and a balance of the type of category i.e. neglect or emotional abuse. The ages of the children and young people ranged between 0 – 13, with eight being under 5 years, four between 5 -10 years and three over 10 years.

2.1.7 A case example from the sample has been included to illustrate the issue of repeat Child Protection Plans (see appendix 1 – Case example).

2.1.8 An electronic audit template was developed with particular thought given to information that should be available in files of all agencies as well as Children's Social Care. It was designed to identify strengths and weaknesses in multi-agency working within the case sample. The use of an electronic audit template allowed for automatic collation of returns, for each case separately and for all cases together.

2.1.9 Case file audits were conducted by agency audit leads who are managers/supervisors in each of the partner agencies working with the individual children and their families. Children's Social Care files were audited using the audit template by a Social Work Practice

[4] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, (2010), March 2013.

Consultant. Agencies within Cheshire East involved in the audits covered a wide spectrum, including: Children's Social Care, Health, Police, Schools, Voluntary Sector, Cheshire East Early Help, Private nurseries, Catch 22, and Youth Offending Service. Clearly, there is wide variation in the degree to which these agencies are involved in directly working with the children and their families.

2.1.10 Auditors were instructed to take immediate action if any audits identified any current practice concern, or to ensure practitioners responded to any issues raised within the audit, or acknowledge good practice. It should be emphasised at this point that none of the cases needed referring for immediate action following the audit.

2.2 Response to audit

2.2.1 There was a positive response to the 90 audit requests that were sent out, with 77 being returned.

2.3 Other sources of data

2.3.1 On completion of the audit a workshop learning event was held with practitioners involved in the cases to discuss the initial findings and to obtain the practitioners' perspective and identify multi-agency learning.

2.3.2 A case example from a frontline practitioner's view has been included to illustrate the issue of repeat Child Protection Plans (see appendix 2 – Frontline practitioner's view).

2.4 Data from family/parents

2.4.1 Telephone conversations were also conducted with a selection of families of the cases involved, to gain their perspective in relation to how agencies are supporting and working with them and also how agencies are working with each other.

2.5 Presentation of findings

2.5.1 The analysis is presented under the following thematic headings**:**

- File/record management
- Background information and previous Child Protection Plan
- The child's daily lived experience
- Repeat Child Protection Plan
- Parents perspective
- Other comments regarding multi-agency working

2.6 Contextual information – repeat Child Protection Plans and the national picture

2.6.1 There are a wide variety of reasons why children are placed on a Child Protection Plan more than once, and in most cases it relates to a parent's addiction, on-going mental health problems, or domestic violence in the home. In some cases it relates to the amount of help that parents who have a learning disability need at different times to look after their children.

2.6.2 At the point when this audit began there were thirty four children subject to a Child Protection Plan for a second or subsequent time. This equates to 16 per cent of the total of Child Protection Plans in Cheshire East (January 2014). The latest national figures available refer to year ending 31 March 2013, when the national average of children subject to a repeat Child Protection Plan stood at 14.9 per cent.[5] Cheshire East is provided with a group of comparable Local Authorities with similar demographic and geographical characteristics. The average percentage of repeat Child Protection Plans for this group of statistical neighbours is 16.1 per cent (2012 – 2013):

Cheshire West and Chester	11.5
Warrington	20.4
North Yorkshire	14.7
Solihull	9.6
Warwickshire	13.3
Worcestershire	19.8
Central Bedfordshire	20.2
Hertfordshire	16.0
Hampshire	14.1
West Berkshire	21.1
Average	**16.1**

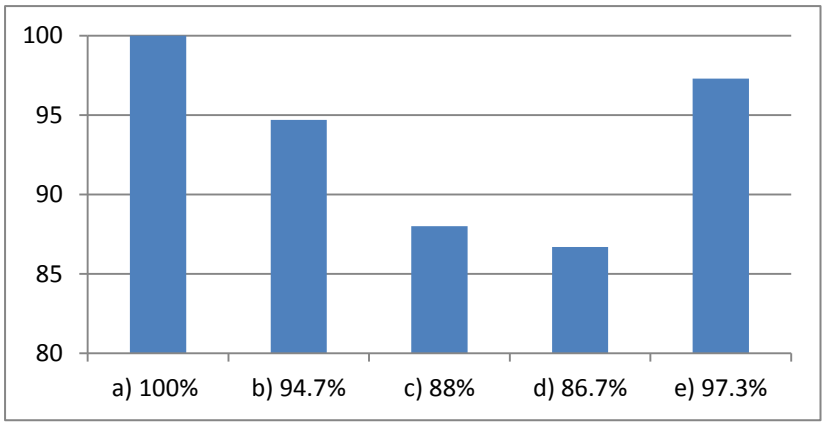
[5] 2012 -2013 Children in Need census.

Section 3: ANALYSIS OF THEMATIC FINDINGS

3.1 File/record management.

Does your agency's file for this child contain?

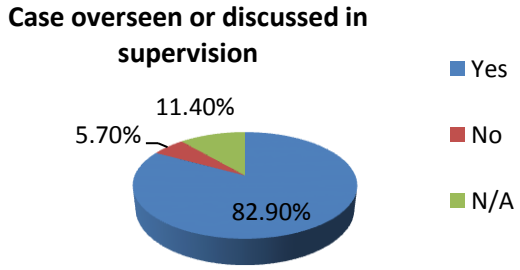
a) Up-to-date basic information for the child?
b) Up-to-date details of other agencies or workers involved?
c) Case summary or chronology of key events?
d) Child Protection Case Conference papers?
e) A marker or alert indicating a Child Protection Plan?



3.1.1 Up-to-date basic information for the child was present in 100 per cent of cases and in almost 95 per cent of cases there were up-to-date details of other agencies or workers involved. In 88 per cent of cases a case summary or chronology of key events was on file. In child protection cases the Child Protection Case Conference papers were on file in just less than 90 per cent of cases. In 97.3 per cent of child protection cases a marker or alert indicating a Child Protection Plan was present.

3.1.2 In addition to these positive results, auditors made comments regarding agency files which identified both positive practice and areas for learning and improvement. A number of comments referred to the case chronology being out of date and in some instances it was several months out of date. Comments were also made about core group minutes not being on the file or were not up to date. In some cases the comments indicate that the Child Protection Case Conference papers are not received, out of date or are lacking sufficient details about the allocated social worker. A number of comments referred to very good case recording which is positive. Keeping chronologies up to date and ensuring that core group minutes and Child Protection Case Conference papers are received and on file are all areas for improvement.

Is there evidence that this child or young person's case has been overseen or discussed in supervision with a manager or safeguarding lead?



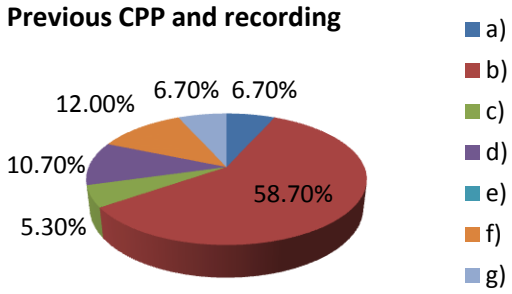
3.1.3 The auditors have identified that in over 80 per cent of the case sample there is evidence of the case being overseen or discussed in supervision with a manager or safeguarding lead. It should be noted that 11.4 per cent of the responses were not applicable and comments indicate that this includes instances where there is no direct involvement from a practitioner that requires supervision. Therefore, the results indicate that in just less than 6 per cent of the sample, the case had not been overseen or discussed in supervision with a manager or safeguarding lead.

3.1.4 Some auditors and practitioners commented on the quality of supervision and the need to improve on the following: timescales for action, reviewing of the previous actions and SMART actions and clearer directions. More than one comment stated that appropriate supervision for a newly qualified social worker is limited.

3.2 Background information and previous Child Protection Plan.

Does your file for this child contain the previous Child Protection Plan and related recording?

a) Yes, this came from a handover or referral from another service or agency
b) Yes, this agency was involved at the time
c) Yes, the current practitioner from this agency was involved at the time
d) Yes, this was received as part of the current Child Protection process
e) Yes, this was provided by child or parent
f) Yes, this was provided by another source
g) No information about the previous Child Protection Plan

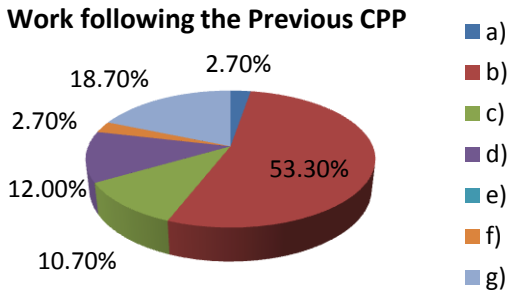


3.2.1 In nearly 60 per cent of the audit responses the previous Child Protection Plan and related recording was contained in the agency file because the agency had been involved at the time. In 12 per cent of cases the previous Child Protection Plan and information was provided by another source and in 10.7 per cent it was received as part of the current Child Protection process. A relatively small proportion (6.7%) of the sample had no information about the previous Child Protection Plan. There were no responses where the information had been provided by child or parent.

3.2.2 These results appear encouraging – specifically that in the vast majority of cases this information has been obtained. Auditors commented that information is disseminated by the Safeguarding Unit and for some agencies the information is accessed via the PARIS electronic case management system (Children's Social Care).

Does your file for this child contain information regarding work with the child or family following the last Child Protection Plan (e.g. Child in Need Plan, CAF, or other support)?

a) Yes, handover or referral information came from another service or agency
b) Yes, this agency was involved at the time
c) Yes, the current practitioner from this agency was involved at the time
d) Yes, information was received as part of the current Child Protection process
e) Yes, information provided by child or parent
f) Yes, information from another source
g) No information about support or intervention since the previous Child Protection Plan



3.2.3 In nearly 20 per cent of the responses it was said that there was no information about support or intervention since the previous Child Protection Plan. On the face of it, this appears to be a gap – as there should have been, for example, a discussion within the Child Protection Conferences of work (if any) since the last Child Protection Plan, and all agencies should have this documentation. It would require more detailed analysis of individual files to fully understand this statistic.

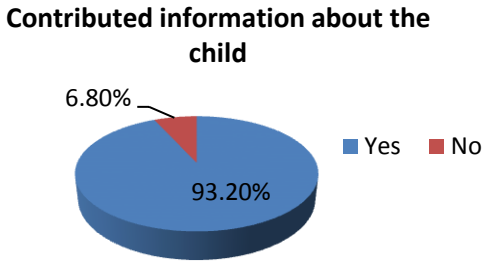
3.2.4 In over half of the responses it was identified by the auditors that their agency was involved at the time. Information was received as part of the current Child Protection process in 12 per cent of responses and in 10.7 per cent the current practitioner from their agency was involved at the time.

3.2.5 Many of the practitioner comments reflected a view that sometimes previous plans were ended too soon and before risks had been properly addressed. A frequent comment in the practitioner workshop discussion in relation to this was about the 'pressure of timescales' – i.e. the practitioners commented that there is a pressure to end a Child Protection Plan within the optimum time frame (both 18 months and 2 years were mentioned) and that this can lead to decisions to end plans inappropriately early (before the risks have been appropriately resolved/addressed). There was also repeated mention from practitioners of families 'knowing the system' (disguised non-compliance – or doing 'just enough when they have to').

3.2.6 Understandably, there were many comments from the practitioners about the advantage of having the same workers who had previously been involved, who were able to be involved in the new episode of the Child Protection Plan. A lot of value is attached to this consistency – although the opposite view was also aired, that it is sometimes helpful to have a fresh perspective from workers new to the case.

3.3 The child's daily lived experience

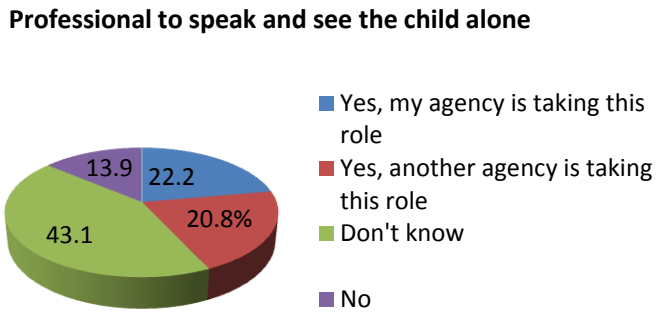
Has your agency contributed to the Child Protection Conference or Core Group's knowledge of the child's lived/daily experience?



3.3.1 In over 90 per cent of the responses it was identified by auditors that their agency contributed to the Child Protection Conference or Core Group's knowledge of the child's daily lived experience. The auditor's comments illustrate how their agencies contribute, for example; regular home visits when the child is seen and spoken with; the child's presentation in school and parent's interaction with school; regular acute health reports are

submitted to case conferences; and the child's daily life is considered as part of the core group.

Has a professional in the Core Group been identified to speak to and see the child alone?

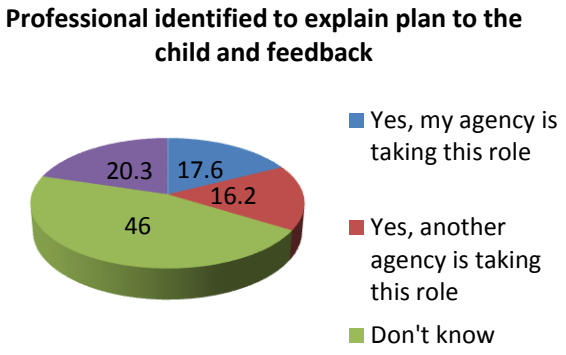


3.3.2 In less than half of the audit responses it is clearly stated that a professional in the Core Group has been identified to speak to and see the child alone. Auditors identified that no professional had been given this role in 13.9 per cent of the responses. This does seem quite high, but may be explained by factors such as the age of the child (8 children in this sample were under five years old).

3.3.3 The response indicates that a very high proportion (43%) of auditors were unable to answer this basic question. This has to be a cause for concern. All agencies need to be clear that the child is being seen appropriately (and if not the reason why), and this should be clearly recorded in all agency case files.

3.3.4 Auditors have made comments that reflect the role their agency has in response to this question, for example: the child is seen during weekly home visits by the health visitor; one to one work with the child by family support worker; and school are exploring the wishes and feelings of the child. A number of comments highlighted that in some cases the child is too young to vocalise their wishes and feelings and to be seen alone. (8 of the sample cases are under 5 years old) In these instances the comments have identified how their agency may obtain relevant information about the child for example: the child is pre verbal but there is a clear description of the child's presentation during home visits; interventions have incorporated observations of the child to elicit his needs/feelings; and observations of the young child are highlighted in bold within the case recording. Auditors did comment that whilst the child is usually being seen, this process is not clearly and systematically recorded for the core group.

Has a professional been identified to explain the plan to the child and feedback the child's response?



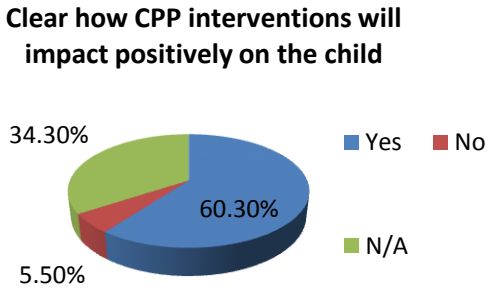
3.3.5 The results for this question are very similar to those for the previous question – and similarly concerning. Again, close to half of respondents were unable to confirm whether a professional has been identified to explain the plan to the child and feedback the child's response.

3.3.6 A number of comments reflect the fact that it is not always appropriate to be directly working with the child in this way – particularly the age of the child ("very young and would not understand the need for the plan - this is a small baby").

3.3.7 There were a number of comments reflecting the fact that whilst it would be an appropriate (and necessary) part of the work, it is not clear that it is being done. For example: "this is not clear, although the child is old enough to understand if plan is explained to her in an age appropriate way"; and "little evidence that this has been done and he is not attending conferences or core groups".

3.3.8 A suggestion from the practitioners' workshop is that children need to be invited to contribute to their plans in a more systematic way. It was further suggested that it could be very helpful to obtain feedback from the child and parent after they have been on a plan to help understand what worked for them – and what didn't – to inform practice.

Is your agency clear about how their actions or intervention within the most recent Child Protection Plan are expected to impact positively on the child?



3.3.9 This appears to be a positive overall response to this question, with the vast majority of agencies - *where it is appropriate* – being clear about how their actions or intervention within the most recent Child Protection Plan are expected to impact positively on the child.

3.3.10 There is a relatively high proportion of not applicable responses. Some of the comments help explain why for some agencies this is not applicable, for example, "no actions required for the police that will impact on the child".

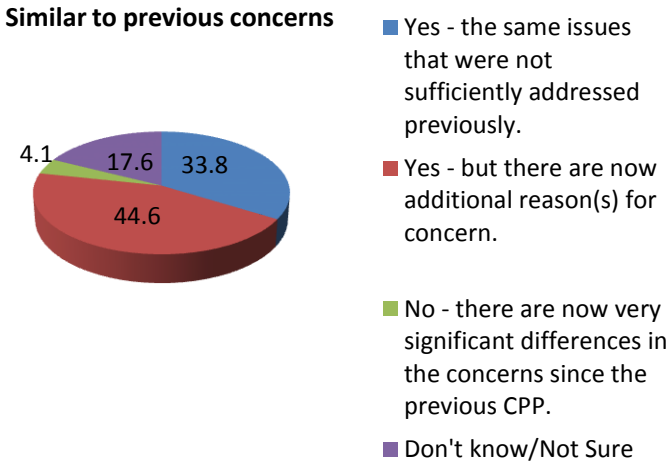
3.3.11 There are some positive comments by auditors including the positive use of the 'desired outcomes' section of the Child Protection Plan to outline the expected impact of the individual actions.

3.3.12 Interestingly, despite the encouragingly small proportion of negative responses to this question, many of the comments made by auditors indicate concern about this area of practice. For example, "not clear enough - core group meetings are general and vague. Main focus is the parents" and "the plan is very vague".

3.3.13 Some practitioners comments reflect an over emphasis on process rather than on measuring the impact on or the outcome for the child. Two examples of this are: "focus too much on process/list of things to do in CP plan"; and "professionals not identifying disguised compliance because plans are all based on tasks and completions of actions rather than impact on the child/changes sustained by parents".

3.4 Repeat Child Protection Plan

In your view are the concerns that led to the most recent Child Protection Plan similar to the previous concerns that led to the previous Child Protection Plan?



3.4.1 It is perhaps not surprising that the auditors have found that in virtually all instances the concerns that led to the most recent Child Protection Plan are similar to the previous concerns that led to the previous Child Protection Plan.

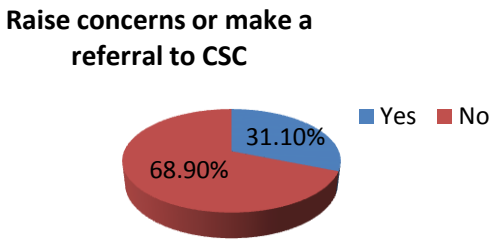
3.4.2 Auditors have identified in 44.6 per cent of the responses that there are now additional reasons for concern.

3.4.3 It is of concern that auditors have identified that in at least a third of cases the issues leading to a repeat Child Protection Plan are said to be the same issues that have not been sufficiently addressed previously. Many of the comments from both auditors and the practitioners reflect this statistic. These include:- "I would question why the initial CP plan was ended as there had recently been a DV incident and there was little evidence of any significant, meaningful intervention"; and "there is evidence of habitual behaviour which has been addressed in the past and risk managed, however, this escalated and compromised the safeguarding of the children".

3.4.4 Practitioners particularly make reference to pressure of timescales leading to Child Protections Plans ending prematurely, for example, "too much pressure/focus on time child has been on plan and need to either escalate or de-escalate. Doesn't give enough time to show family can sustain changes".

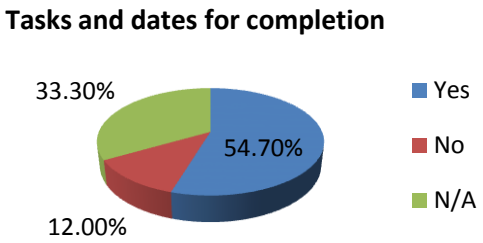
3.4.5 Some of the comments are more positive about the previous work undertaken such as, "yes the same issues apparent, and from records appears that issues were sufficiently addressed previously with all appropriate support/intervention with significant progress made".

In the period between the previous and most recent Child Protection Plans, did your agency raise concerns or make a referral to Children's Social Care?



3.4.6 The statistical response to this question does not lead to any definite conclusions. The comments made by auditors suggest that in general where referrals were made these were dealt with appropriately, for example, "School nurse raised concerns about alcohol consumption. This was investigated and led to the case going back to conference".

In the most recent Child Protection Plan, are the tasks and dates for completion for your agency clear?



3.4.7 In just over half of the case sample auditor's said that the tasks and dates for completion by their agency were clear. In a third of the responses this question was said not to be appropriate and it is indicated within the comments that this relates to agencies where there are no identified tasks or no direct agency involvement. The number of instances where there is said to be lack of clarity about the tasks and dates for completion appears to be reasonably small – at only 12 per cent of the overall returns.

3.4.8 The auditor's comments suggest that tasks and timescales are generally clear, however, in a number of the cases timescales are either absent or just stated as 'on-going'. In these cases an exact and achievable timescale would give more focus and is an area for improvement.

3.4.9 The practitioners' workshop provided a lot of useful discussion and suggestions. They were provided with a number of hypothesis/scenarios in order to generate discussion about their own practice experience of repeat Child Protection Plans in Cheshire East. This included whether repeat plans are an appropriate response to changing family circumstances and risk; whether the previous plan had been closed before risks had been properly addressed; whether support plans following the previous Child Protection Plan were not properly made or properly delivered; and whether changes of practitioners brought different views of risk.

3.4.10 There is an acceptance from practitioners that repeat Child Protection Plans are inevitable in complex and fluctuating family circumstances. They do highlight that once a plan has closed there can be gaps in resources or service provision, and indeed that there can be a tendency for families to 'disengage' (cease working with professionals). Comments were made that in order to show that the family is able to sustain changes, there needs to be careful consideration about how quickly it is appropriate to end Child Protection Plans, and indeed whether there should be slower de-escalation to/from Child in Need and CAF interventions.

3.4.11 Practitioners clearly feel that at the point of a repeat Child Protection Plan there is an imperative to ensure a tight focus on timescales and outcomes for the child – including consideration of legal processes (the suggestion was made that raising awareness across agencies of Public Law Outline (PLO) process would be useful).

3.5 Parents perspective

3.5.1 Telephone conversations were conducted with a small selection (three) of parents involved in the audit, to gain their perspective in relation to how agencies are supporting and working with them and also how agencies are working with each other.

3.5.2 All the parents spoken with during this audit felt that professionals were clear with them about help and support offered or provided after the previous Child Protection Plan, for example, *"good support from professionals when the CP plan ended".* However, in one example a parent commented, *"when support ceased we found it difficult to contact people" and "felt we were left to our own devices".*

3.5.3 Parents understood the reasons for ending the previous Child Protection Plan, for example, *"the reasons for ending the previous CP plan were clear".* They were also clear about the reasons for the repeat Child Protection Plan, for example, *"the main reason this time is due to my misuse of alcohol".*

3.5.4 When asked about the impact of being involved in a repeat Child Protection Plan, parents comments included, "*the current plan is for the same reasons as before, but agree it is right due to the risks posed"* and *"things need to change and the Child Protection Plan is now helping that to happen" and "being on a plan this time as helped me a lot".*

3.5.5 Another parent commented, *"very disappointed that the current social worker is leaving, as she has been open, honest and understanding".*

3.6 Other comments regarding multi–agency working

3.6.1 A further question asked auditors to identify any particular areas of strength, good practice, and deficits in practice or concerns. This has generated many detailed comments illustrating good practice as well as some examples of areas that require improvement.

3.6.2 It is notable that the vast majority of the comments highlighted positive practice that the auditors had identified. There are four main themes that emerge from these positive comments, and these themes are crucial in effective multi–agency working in Child Protection: - good clear and concise case recording; good communication and information sharing between agencies; clear SMART plans and clarity about tasks; and children's views are clearly sought and addressed. Examples of these include:-

"The recording is very clear and there is a SMART plan in place"

"the social worker's core group minutes and recordings are very in-depth"

"visits to the child are well recorded and there is clarity about the child's views"

"good communication between professionals, clear planning/task, detailed chronology, positive evidence to show consultation and engagement with parents"

“the social worker ensures all agencies receive the relevant paperwork in a reasonable timescale. The actions and responsibilities are clear within the plan. The meetings are clear in focus and transparent. The family is aware of the outcomes should they fail to engage with the support in place to reduce the significant risk of harm to the children”

“strength of FSW in CEFS is that clear, detailed observations capture child's view and reflective practice inform next steps”.

3.6.3 The areas of concern identified by the auditors’ comments cover quite a variety of different issues (and include some of the areas where good practice was highlighted by other auditors). There were a number of comments regarding paperwork/information exchange – particularly highlighting problems of core group minutes not being sent out in a timely fashion or being on file (one mention of conference minutes also in this regard) as well as there not being a ‘robust chronology’ available. There were several comments related to the difficulty of there being changes of worker and the impact of this lack of consistency of workers (particular social workers). The quantity and quality of supervision (or the recording of that) is also something which generated comments. A selection of these comments is provided below:

“lack of supervision, visits and management decision making”

“voice of the child, involvement of child, feedback to child needs to be a greater focus in CIN process”

“more emphasis should have been placed by all agencies to explore the child's lived experience in that family”

“audit of this case has identified deficits in practice in relation to absence of Child Protection Minutes and Core Group Minutes”

“the Initial CPP was only in place for 6 months this was a very short time to evidence sustained change”

“there have been a number of social workers allocated to this family and this is concerning - concern that this is leading to a lack of consistency in relation to monitoring and ensuring that actions for the family are clear and being undertaken”.

Section 4: CONCLUSIONS AND RECOMMENDATIONS

4.1.1 By definition, it is always a cause for concern for a child if they are assessed by professionals to be at risk of significant harm and in need of a Child Protection Plan. For any child who has previously experienced an episode of being subject to a Child Protection Plan, the decision that there needs to be a repeat Child Protection Plan for them is arguably always an indicator of increased concern about that child's current situation and the prospect of future positive outcomes. It should also be a trigger to professionals to re-evaluate the effectiveness of previous and current interventions with the child and their family. There are a variety of different reasons why children may become subject to a Child Protection Plan for a second or subsequent time, and it should be stressed that such an event is not necessarily an indication of any deficiency in planning, in intervention or in interagency working (it can, for example, be the result of significant, unpredictable changes within the family).

4.1.2 That said, the number of the repeat Child Protection Plans seen within a Local Authority area is often used as one measure of the effectiveness of the safeguarding system, or an indicator of the thresholds of risk in operation. As stated previously, at the time when this audit began the number of repeat Child Protection Plans seen within Cheshire East is slightly higher than the national average, (although it is not out of kilter with the numbers for the identified 'statistical neighbours'). This audit has not been given the remit of analysing whether the overall numbers of repeat Child Protection Plans is appropriate or to research the reasons behind this number. Instead, the purpose here has been to audit a selection of cases where children are subject to repeat Child Protection Plans, in order to look at different areas of interagency practice to see what themes emerge - evidence of good practice and areas which require improvement.

4.1.3 It is notable that the analysis of the data provided by the audit responses, the comments from the auditors themselves, the workshop with the practitioners who were involved with these cases, and indeed, the comments from parents all readily point to positive indicators of good practice.

4.1.4 The audit produced some very positive statistical results in relation to the information contained on agency files (see bar chart under 3.1 above). The audit also demonstrated that in a very high percentage of cases (where appropriate) there is clear evidence on files that there has been management oversight of the case. There does appear to be very good exchange of relevant documentation (such as previous Child Protection Plan) between agencies – the important role of the safeguarding unit in disseminating this documentation was recognised.

4.1.5 The importance of chronologies for practitioners working on a case cannot be overstated, and it is very encouraging that a very high percentage of case files are said to contain a case summary or chronology of key events. It appears from comments made that there may be issues in relation to ensuring these chronologies are kept up to date. Similarly, comments from auditors and practitioners indicated there may be a need to look more thoroughly at the content and/or quality of supervision provided in some instances.

4.1.6 It is crucial in all child protection work that a clear focus is maintained on the daily lived experience of the child. Practically all of the responses indicate that all the agencies are contributing to the understanding of the child's experience. This is very encouraging, and there is clearly some very positive work being undertaken to ensure that children's views and experiences are considered. However, the audit has also uncovered that there is significant room for improvement within this vital area of the work. All agencies need to be clear that the child is being seen appropriately (and if not the reason why), and this should be clearly recorded in all agency case files, however the audit responses were far from satisfactory in this regard. Similarly, it should be clear from all agency files whether a professional has been identified to explain the Child Protection Plan to the child and feedback the child's response (and if not the reason why). Almost half the auditors did not know from the file whether or not this is happening. This is clearly an area for improvement - and indeed is presented as a finding below (Finding 1). It is suggested that this should be a mandatory agenda item for all core group meetings and that all core group minutes should reflect that this is being addressed. Further positive suggestions from participants of this audit are that children should be invited to contribute to their plans in a more systematic way, and that feedback from the child and parent could be sought after they have been on a plan to help understand what worked for them – and what didn't – to inform practice.

4.1.7 A third of the audit responses indicate that the concerns leading to the second Child Protection Plan were the same as those leading to the previous plan and that the issues had 'not been sufficiently addressed' previously. The audit encountered the repeatedly stated view that previous Child Protection Plans were ended prematurely, that change had not been shown to have been sustained and that following de-escalation from the Child Protection Plan the interventions 'tailed off', and also that parents disengaged (or were allowed to disengage) from attempts to work with them. Further, a view expressed a number of times to the audit is that that there is a disproportionate pressure on ending a Child Protection Plan within an acceptable timescale, and that this pressure interferes with the imperative on professionals to ensure that the intervention has had a significant (and lasting) impact on the risks to the child. In this regard there were comments that the process of implementing Child Protection Plans can become an exercise in ensuring that tasks are carried out - in a 'tick box fashion' – so that once the tasks have been completed, it is assumed that the Child Protection Plan should end, without there having been an adequate evaluation of the impact of the interventions on the child and on the risks.

4.1.8 It should be stated that there was quite a positive response to the question about whether agencies are clear how interventions in the most recent Child Protection Plan are expected to impact on the child (with less than 6% of respondents saying this was not clear). It would appear that effort is being made to plan interventions in line with the principles of SMART planning, but from evidence highlighted to this audit, it is clear that there is still significant room for improvement with this. This is demonstrated by the number of comments expressing concern about plans not having tight timescales, ending too prematurely, and an over-emphasis on process rather than on impact on the risks to the child. This is therefore presented as Finding 2 below.

4.1.9 Many comments were made to the audit (from auditors, practitioners and parents) that changes in allocated workers can have a significant impact on the work being undertaken. Indeed, there were also comments from all these sources about the negative impact his can have upon crucial working relationships (between professionals and with the family) – which in itself will also have an impact on the effectiveness of the intervention. It is thus necessary to reproduce a recommendation included in a previous audit (Multi-Agency Case Audit and Case Mapping Peer Review Report – January 2014) – about the importance of trying to maximise consistency of workers – presented as Finding 3.

4.1.10 This audit has clearly identified evidence of areas of multi-agency practice where there does need to be significant improvement – and these are presented as the main 'Findings' below.

4.1.11 There is undoubtedly room for improvements in other areas, so that, for example, **all** agencies are **always** clear about the tasks they are to undertake, and that they are **always** clear about the impact of their interventions on the child. Whilst the evidence base has not been so strong for there to be other clear 'Findings', there are some other recommendations which follow from the analysis within this audit.

These would include ensuring that:-

- chronologies are kept as accurate and up to date as possible;
- there is a quality assurance process to evaluate the content and quality of supervision across agencies;
- there is consideration to further raising of awareness across agencies of Public Law Outline processes;
- a focus for training across agencies should be on identifying disguised compliance from parents.

Section 5: FINDINGS

Finding 1: In too many cases, auditors were not able to comment with certainty on some basic questions about the work being undertaken with children and young people. Specifically, it was not clear from agency files that children are being seen on their own by a professional or that a professional is explaining the plan to them.

Challenge for CESCB:

- **CESCB need to satisfy themselves that children subject to Child Protection Plans are being seen appropriately and that this is clearly evidenced on all agency case files - and when this is not happening the reasons are also clearly recorded.**

Finding 2: SMART planning is not consistently embedded in practice across the agencies.

Challenge for CESCB:

- **To ensure that all planning (not just for Child Protection Plans – but also Child in Need (CIN) and Common Assessment Framework (CAF)) is based on clear SMART principles, and are clearly targeted on the impact that the individual actions have upon the risks to the child.**

Finding 3: Changes in allocated worker can impact on the work being undertaken. This appears to be an issue across all agencies, but comments highlight the particular importance of the social worker who is often the lead professional.

Challenge for the CESCB:

- **To take action to maximise the consistency of allocated workers across agencies.**

Section 6: References.

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, (2010), March 2013

Children Act 2004

Local Safeguarding Children Boards Regulations, 2006

Children in Need census, 2012 -2013

Section 7: Appendices.

Appendix 1 – Case example from the audit sample.

Child A is 14 year-old white British young man, middle child of older and younger male siblings.

The family was previously known to Children's Social Care in relation to long-standing domestic abuse issues (linked to alcohol), some of which related to Child A's older brother.

Child A was made subject to a Child Protection Plan with his younger brother in November 2010, following an incident of parental neglect towards his younger brother, and a number of other concerns including Child A's poor school attendance, behaviour and academic progress. The Child Protection category was Emotional Abuse because of the negative influence of domestic abuse on many aspects of family life. The Child Protection Plan included a number of actions, which included domestic abuse support for the mother. In relation to Child A, the actions included, support at school and a referral to the Safeguarding in Education Team for support work around domestic abuse.

The Child Protection Plan was closed in March 2012, following progress on domestic abuse issues for the family, with father and older brother having left the family home. Although, issues still remained for Child A, regarding school behaviour, poor academic progress, and possible ADHD, but school attendance had improved. The Child Protection Plan was stepped down to a Child in Need Plan for three months, which was then closed because of 'no outstanding tasks.' No Common Assessment Framework was put in place following the closure of the Child in Need Plan.

During 2013, school attendance deteriorated leading to the involvement of Educational Welfare, and a Child & Adolescent Mental Health Service appointment for ADHD was refused. A referral was made to Children's Social Care following episodes of Missing from Home, when Child A slept rough with his father and older brother, and there were concerns about his exposure to drugs and alcohol abuse, and criminal associates.

A Child Protection Plan was put in place in December 2013 in the category of Neglect, and a referral was made to the Youth Engagement Service for work around the prevention of offending.

Missing from Home episodes prompted a referral for Return Home interviews with Catch 22. An account of multi-agency work with Child A is provided by a Catch 22 practitioner in the following Appendix 2.

Appendix 2 – Frontline practitioner's view.

I became involved with this 14 year old boy who was placed on a repeat Child Protection Plan following a few concerning Missing From Home Episodes where the young person was sleeping rough with his older brother and homeless father. I was unable to carry out a Return Interview as per Pan Cheshire Protocol as the young person's mother was suspicious of services and had previous negative involvement with Social Care. I maintained close contact with the Social Worker from the CIN/CP team, who had given me a good update on the family history and he had made himself aware of Social Worker responsibilities in regards to the Missing from Home Protocol.

A Child Protection Conference was held in respect of this young person and his younger brother. These 2 brothers along with their now 19 year old elder brother had previously been subject to a Child Protection Plan. A lot of the behavioural concerns for the 14 year old were starting to mimic those of his older brother when he was the same age. I felt that the Social Worker and team of professionals involved with the family took careful consideration about the family history when making decisions on this case. It was decided that the 14 year old would be placed on a Child Protection Plan.

In this case, the child's perspective was not able to be gained. Myself, the Youth Engagement Service, Educational Welfare Service and the Social Worker all made significant attempts to meet with the young person. This was done persistently and creatively, however the young person refused to engage and would not be present when visits were arranged. He would also refuse to engage when professionals dropped by unannounced. He did spend a few hours at school on one day and school tried to engage him in conversation about everything that was going on, however he then verbally abused staff and then absconded. It was felt by all professionals that this showed the complexities and chaotic nature of this young person's lived experience at the time.

I feel that multi-agency working was very positive in this case. As mentioned above there were a large number of agencies involved and all agencies worked very well at communicating and sharing information when they were able to meet with the family. It was also understood and agreed upon by agencies that given the complex nature of the case that one service should take a lead in trying to engage with both the mother and the young person so that this could then foster positive relationships with the family and then facilitate the family's willingness to engage with other relevant and appropriate services. I think if improvements could be made in this case, I think that a lead agency should have been identified earlier on given the family's history of distrusting and disengaging from professionals, rather than lots of services attempting to engage and all failing initially which then made it harder when the decision was made to reduce the amount of professionals all trying to meet with the young person and the family.

Appendix 3 - Audit template questions.

CESCB Case Audit - repeat Child Protection Plans

1) Does your agency's file for this child contain?

☐ up-to-date basic information for the child (name, date of birth address, parent or carer's details, etc.)

☐ up-to-date details of other agencies or workers involved

☐ case summary or chronology of key events

☐ Most recent Child Protection Plan, Case Conference and Core Group papers

☐ A marker or alert on the file indicating a Child Protection Plan (if the Plan has closed very recently, please state below)

Comments:

2) Is there evidence that this child or young person's case has been overseen or discussed in supervision with a manager or safeguarding lead?

○ Yes

○ No

○ Not applicable

Comments:

3) Is there evidence that this child or young person's case has been overseen or discussed in supervision with a manager or safeguarding lead?

○ Yes

○ No

Comments:

4) In the most recent Child Protection Plan, are the tasks and dates for completion for your agency clear?

○ Yes

○ No

○ Not applicable

Comments:

5) Is your agency clear about how their actions or intervention within the most recent Child Protection Plan are expected to impact positively on the child?

○ Yes

- No
- Not applicable

Comments:

6) Has your agency contributed to the Child Protection Conference or Core Group's knowledge of the child's lived/daily experience?

- Yes
- No we do not have information to contribute

Comments:

7) Has a professional in the Core Group been identified to speak to and see the child alone?

- Yes, my agency is taking this role
- Yes, another agency is taking this role
- Don't know
- No

Comments:

8) Has a professional been identified to explain the plan to the child and feedback the child's response?

- Yes, my agency is taking this role
- Yes, another agency is taking this role
- Don't know
- No

Comments:

9) Does your file for this child contain the previous Child Protection Plan and related recording?

- Yes, this came from a handover or referral from another service or agency
- Yes, this agency was involved at the time
- Yes, the current practitioner from this agency was involved at the time
- Yes, this was received as part of the current Child Protection process
- Yes, this was provided by child or parent
- Yes, this was provided by another source (please comment below)
- No information about the previous Child Protection Plan

Comments:

10) Does your file for this child contain information regarding work with the child or family following the last Child Protection Plan (e.g. Child in Need Plan, CAF, or other support)?

- Yes, handover or referral information came from another service or agency
- Yes, this agency was involved at the time
- Yes, the current practitioner from this agency was involved at the time
- Yes, information was received as part of the current Child Protection process
- Yes, information provided by child or parent
- Yes, information from another source (please comment below)
- No information about support or intervention since the previous Child Protection Plan

Comments:

11) In the period between the previous and most recent Child Protection Plans, did your agency raise concerns or make a referral to Children's Social Care?

- Yes (please comment below on the outcome)
- No

Comments:

12) In your view are the concerns that led to the most recent Child Protection Plan similar to the previous concerns that led to the previous Child Protection Plan?

- Yes - the same issues that were not sufficiently addressed previously.
- Yes - but there are now additional reason(s) for concern.
- No- there are now very significant differences in the concerns since the previous Child Protection Plan
- Don't know / Not Sure

Comments:

13) Has the audit of this child's case identified any particular areas of strength, good practice, deficits in practice or concerns? (it is expected that any significant concerns wil be brought to the attention of your manager immediately)

- Yes (please describe briefly in the comments box below)
- No

Comments:

14) We would like to arrange telephone conversations, where appropriate, with families involved in this audit. Would you be able to help us make contact with this family?