Cheshire East Local
Safeguarding Children Board

MULTI-AGENCY CASE AUDIT REPORT CONCERNING:

Children - where interventions have been stepped down.

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Table of Contents

Section 1: Introduction 3

1.1 Background 3

1.2 Terms of reference 3

Section 2: Audit Methodology 4

2.1 Aim 4

2.2 Process 4

2.3 Learning from the process 5

Section 3: Analysis 6

3.1 Brief overview 6

3.2 Assessment and analysis of the child's and family's needs. 6

3.3 Planning for the child and family. 15

3.4 The step down process in action. 17

3.5 Challenge and Escalation. 19

3.6 Other sources of data. 20

Section 4: Conclusions 24

4.1 Summary of findings 24

Section 5: Recommendations 25

Appendices 26

Appendix 1: CESCB Multiagency audit tool – step down 26

Appendix 2: A brief overview of each of the cases 31

References 34

Section 1: Introduction

1.1 Background

1.1.1. The Children Act (2004)[1], places a statutory duty on partners to safeguard and promote the welfare of children, and the statutory guidance 'Working Together to Safeguard Children' (2015)[2], expects children and adult services to work cooperatively together.

1.1.2. Local Safeguarding Children Boards (LSCBs) are required, as part of their statutory duties and functions, to quality assure the effectiveness of its members' practice.

1.1.3. Multiagency audits of case files that relate to a specific theme are considered to be an effective way of providing the LSCB with assurance, particularly if practitioners and their managers are involved in identifying what they are doing well and where improvements need to be made.

1.1.4. Cheshire East Safeguarding Children Board (CESCB) has established a rolling programme of multiagency audits which are in line with the Children's Improvement Board's Quality Assurance Framework.

1.1.5. The theme of this audit concerns children, when interventions have been stepped down through the thresholds. This may be; from Child Protection to Children in Need (CIN), from CIN to Common Assessment Framework (CAF) or closure to Children's Services.

1.1.6. The theme has been chosen in response to concerns raised by Ofsted Inspectors and Independent auditors; who found, in a small number of cases, that the step down process had been applied prematurely.

1.1.7. The CESCB wants to gain assurance through this audit that children are not being put at risk and that a child's journey is safe and plans are effectively managed and monitored as interventions are stepped down.

1.1.8. An important part of the audit is to draw lessons from practice and share learning across the partnership.

1.1.9. This report draws on evidence from eight cases where the needs of children and their families have been deemed sufficiently resolved enough for interventions to be stepped down.

1.1.10. The report provides an overview of the findings under the themes of: Assessment and analysis, planning for the child and family, the step down process in action, and challenge and escalation; leading to conclusions and recommendations.

1.2 Terms of reference

1.2.1. The established terms of reference for CESCB multi-agency audits are as follows:

- Quarterly audit with an alternate emphasis on quantitative and qualitative information through audits of 8 cases.

[1] The Children Act, 2004

[2] Department for Education, March 2015 "Working Together to Safeguard Children": A guide to inter-agency working to safeguard and promote the welfare of children.

- 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 CESCB Executive Group and the Children's Improvement Board.

Section 2: Audit Methodology

2.1 Aim

2.1.1. A vital component of a child's journey is the work undertaken by practitioners in providing services and supporting the child to move through the various services in order to ensure their needs are met. The journey should be underpinned by good inter-agency working.

2.1.2. This audit tool (see Appendix 1) is intended to take a closer look at how agencies understand and work with children and families when interventions are stepped down through the thresholds from children requiring statutory services to needing targeted or universal services to meet their needs.

2.1.3. The CESCB needs to understand in more detail, and from a multiagency perspective, if/why cases are stepped down prematurely, in order to make improvements, whilst also identifying and sharing good practice.

2.2 Process

2.2.1. A sample of eight children was identified by the CESCB's Business Manager using the Children's Services electronic data system (see Appendix 2 for a brief outline of each case).

2.2.2. The criteria used to select the cases included: Step down as a key factor in the case, and where possible a mix of ages, sex, and ethnicity, differing levels of intervention, and cases from Macclesfield and Crewe.

2.2.3. Partner agencies were are asked to check records to see whether the index child, their siblings or those with parenting responsibility were known to their agency.

2.2.4. Auditors from each agency were identified and tasked with auditing the selected cases.

2.2.5. Auditors were asked to review records for a maximum of 24 months preceding the referral to Children's Social Care.

2.2.6. Auditors were asked to complete the audit tool and comment on how the work of practitioners and services considered the child.

2.2.7. Agencies were required to act on any findings about practice in their own agencies.

2.2.8. The CESCB appointed an independent auditor to analyse the findings and produce a report.

2.2.9. Practitioners involved in the cases were invited to a workshop in order to consider some key findings and to provide a view.

2.2.10. A number of families, whose files were subject to the audit, were contacted in order to ascertain their views on how agencies worked together to meet their needs.

2.2.11. A number of strategic leaders from the agencies involved in the cases were contacted in order to gain a view on the emerging findings.

2.3 Learning from the process

2.3.1. All the questionnaires that were distributed were completed.

2.3.2. No questionnaires were requested from adult services other than those completed on behalf of General Practitioners (G.Ps). The gap was obvious when domestic abuse and mental health was a feature; additionally in these cases responses from housing providers would have also been beneficial.

2.3.3. There was not a complete set of questionnaires covering every child in the family. It is important to make sure that agencies are invited to take part in the audit if they have worked or are currently working with the family, because as well as agencies involved in stepping up and stepping down, there are services that step in and step out.

2.3.4. It is important not to over rely on the Survey Monkey audit summary which generalises responses and in a small audit this can mask the real issues.

2.3.5. There was an issue in interpreting the findings where staff had ticked "don't know", as some staff e.g. police and midwifery are no longer involved in the case and therefore not in a position to answer the question. In future these responses need to be broken down so it is easier to identify why staff do not know. The reader is therefore asked to apply a degree of caution to any "don't know" reports.

2.3.6. Some of the detail provided to auditors was not sufficient for them to identify the case and for this reason only four out of the eight cases had a G.P questionnaire completed.

2.3.7. Auditors need to be advised on how to complete the questionnaire in order to get the best out of the analysis. Some auditors gave very little explanation for the answers they gave and some left questions unanswered.

2.3.8. Ideally the auditors should see and comment on the questionnaire before it is finalised so that they can raise any questions about interpretation. Auditors need copies of the questionnaires they have completed for their future reference.

2.3.9. Some lead professionals were slow to/did not return a brief case summary which delayed the process of analysis. The quality of the summaries also varied.

2.3.10. As with any small audit there is a need to ensure findings are not generalised whilst taking sufficient account of emerging issues and views.

2.3.11. Information obtained from speaking to parents, strategic leaders and practitioners was extremely useful in providing clarification about some of the emerging findings.

Section 3: Analysis

3.1 Brief overview

3.1.1. Of the eight cases involved in this audit; three cases were unborn or babies under one year, three cases involved pre-school children some with siblings at school and two cases involved school aged children.

3.1.2. Three of the cases were stepped down from Child Protection (CP) to Children In Need (CIN), one case was stepped down from CP to Common Assessment Framework (CAF), one case was stepped down from CP to closure, one case were stepped down from CIN to CAF and two cases were stepped down from CIN to closure.

3.1.3. Four of the cases involved domestic abuse and as a result the children suffered emotional abuse, one case involved a child making an allegation of sexual abuse, one case concerned the neglect of children, one case involved a child with aggressive and early offending behaviour and one case was about historic concerns about mother's parenting and her relationship with a sex offender (see Appendix 2 for case summaries).

3.1.4. There were two cases in which agencies disagreed with the decision to step down, only one of these was challenged and escalated.

3.1.5. There were two cases where health staff raised concerns with Children's Services about the number of changes of social worker and cancelled meetings.

3.1.6. There was some evidence of effective joint working and good information sharing. Attendance of partners at multiagency meetings was good and positive outcomes for children were reported in some cases.

3.1.7. Partner agencies demonstrated how they had assessed and taken into account the voice and perspective of the child.

3.1.8. There was also evidence of premature decision making to step down when assessments and actions were incomplete and evidence of sustained improvement was missing, this was particularly but not exclusively, when domestic abuse was a factor.

3.2 Assessment and analysis of the child's and family's needs.

3.2.1. There was strong evidence within the audit sample that the child's view was being taken into account. 81.6% believed that they were meeting the requirements to represent the experience of the child.

3.2.2. Partner agencies, in some cases, were able to evidence what assessment tools they had used and how this had informed their analysis. There was a lower percentage at 67.6% that felt the collective experience of the child was informing their agency activity. It is imperative that collective analysis of children's wishes, experiences and perspectives inform where appropriate, any plans that affect their lives.

3.2.3. In their assessment practitioners must reflect on the child's perspective and their daily lived experience and any risks and/or needs must be considered in the decision to step down services. In this sample 29% said this was the case, 15.8% said it wasn't and just over half said they did not know.

3.2.4. In case one where the children had been exposed to domestic abuse, pre-school staff used one-to-one and group sessions to help the child talk about ideas, thoughts and experiences. They tracked the child's development and ensured a speech and language referral was made. They reported improved outcomes following the intervention and the child is making progress and is much happier with life at home.

3.2.5. In the same case school staff reported improvements in one of the children's attainment and progress following the intervention.

3.2.6. The G.P in the same case had spoken to one of the children alone. Additionally the G.P was requested to and did attend a review meeting to provide more detailed information on the mother's health. Whilst it is recognised nationally that there is a challenge arranging meetings to facilitate G.P attendance, the G.P responded positively to this request. This was effective practice on behalf of the Social Worker, as lead professional, in ensuring the G.P information informed the assessment and plan.

3.2.7. The audit sample showed that partner agencies did prioritise their attendance at multiagency meetings. There was concern and challenge from Child and Adolescent Mental Health Services (CAMHS) when they had not been made aware/invited to meetings in Case 6. This aspect of partnership working is critical to ensuring safe decision making for children. In Ofsted's, November 2014, Progress Inspection Report[3], it was noted that attendance by partners at multiagency meetings, in Cheshire East (CE), was inconsistent.

3.2.8. The Children's Services auditor, in Case 1, reported some evidence of analysis and she noted that there was improvement in the situation for the children. However, it was felt that a more detailed analysis in terms of the impact of domestic abuse, the parental disabilities and the emotional harm the children had suffered was required.

3.2.9. In the survey responses for Case 1 the complexity of the issues were recorded by the agencies and these included children's exposure to; domestic abuse, mental health of parents, the home environment and outstanding health issues. There was evidence that partners had worked well together.

3.2.10. The auditors did not report, however, that the complexity of all these issues on the children and their mother and the long standing history of social care involvement required scepticism in terms of the mother's ability to sustain the progress.

3.2.11. Parental separation alone and the short term improvements this would bring are not enough. In domestic abuse research separation often increases the risk of domestic abuse, it is also well documented that relationships regularly rekindle. That aside there was also the long history of mother's difficulties with parenting.

3.2.12. The school auditor summed this up by saying that school still have to deal with the lack of parenting skills and emotional needs and wellbeing of the children on a daily basis. It is unclear if these views were represented as a challenge at the multiagency meeting when a decision to step down was made.

3.2.13. Of concern in Case 1 was that when it was stepped down to CIN, mother requested that the School Nurse withdraws from the plan. This is unacceptable when there are outstanding

[3] Ofsted. Nov 2014, Progress Inspection Report, in Cheshire East.

health needs. It was clear that the School Nurse hoped to continue with the planned health assessment but this will require mother's consent.

3.2.14. The change of Social Worker at the point of step down in Case 1 is a concern given what has been said about the mother, and it also brings the added risk of starting again. There were a number of changes of both health staff and social worker in this case.

3.2.15. In Case 2 the baby was exposed to significant domestic abuse and the mother was young.

3.2.16. The unborn child's view was represented based on this history which is good practice. Munroe (2012)[4] supports the fact that the unborn child's history can be represented as proxy for the voice of the child.

3.2.17. The Multiagency Risk Assessment Conference (MARAC) meeting apparently judged the father to be a high risk to partners and anyone who attempts to intervene. Research around violent fathers' shows that this fact can often constrain effective practice. A consideration of this issue needs to be considered amongst professionals, who need to challenge if there is evidence of this occurring. The Social Worker did not, apparently, receive supervision in this case; supervision would have provided another forum to explore whether practice was being constrained. The Family Nurse did receive regular supervision.

3.2.18. Ofsted (2010)[5] found that there was a tendency for agencies to overlook the role of fathers, male partners and other men living in the household. This appears to be true in Case 2 other than a record, by the Police and Family Nurse that the father was expected to complete a perpetrator programme before he could have contact with the child and then contact would be supervised by maternal grandmother.

3.2.19. The mother's feedback to this audit was that she felt the support her ex-partner received could have been improved.

3.2.20. In this case the Children's Services auditor is clear that a specific domestic abuse assessment tool should have been used with the mother and father to evidence their understanding of the impact of domestic abuse and to inform future planning.

3.2.21. Case 2 was reported by the health auditor to show evidence of good multiagency working and information sharing. There was a clear picture of the child's health and development and the parenting capacity of the mother. The Family Nurse Partnership's national assessment tools were used to analyse and inform decision making.

3.2.22. The family received intensive home visiting as part of the Family Nurse Partnership with visits every two weeks.

3.2.23. The assessment in case two however showed evidence of disengagement by the mother. The case summary that was received to support the audit questionnaire, says there was a period of about six weeks when the mother was not available for Social Work visits. The Family Nurse was also having visits cancelled, although the mother would rearrange the appointment. Given the history this type of disengagement is a significant concern.

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[4] Munroe, E. 2012. Progress Report: Moving towards a child centred system.

[5] Ofsted (2010) The voice of the child: Learning lessons from serious case reviews.

3.2.24. Ofsted (2010)[6] highlights the need to be alert to parents who deny access to children as when this happens the practitioners are unable to represent the child's view or make observations about the interactions.

3.2.25. Once again, as in Case 1, a healthy scepticism needs to be maintained. It may well be the case that when mother and child were seen together there were no concerns but she could have been disguising her compliance.

3.2.26. There were a number of changes to the Social Worker; health records say there were six changes in Case 2 which is extremely high considering the age of the baby. This also resulted in meetings being cancelled which can dilute the level of concern with families and also prevent plans being updated and developed as a result of changing needs. In this case there was a new partner and any risks needed to be assessed quickly.

3.2.27. Numerous changes of worker can interfere with; the assessment and planning process, relationships with the family, and communication and information sharing with professionals. There was also a concern with the number of changes in Social Worker in Cases 6 and 7.

3.2.28. Munroe (2012)[7] talks of a clear message from children (and their families) - they value continuity in their relationships. To talk openly about personal and often painful problems requires a degree of trust in the professional and changes of worker mean that the trust has to be redeveloped with someone new.

3.2.29. In Case 3 the index child, aged one year, had been exposed to domestic abuse from the father, along with the siblings from another relationship. There were only two questionnaires completed in this case, one from Children's Services and one from the Police. There should have been questionnaires from health visiting, the G.P, and others agencies like schools. There is no explanation why the returns relating to this case were so low, with the exception of the G.P auditor, who said that the family details must have been incorrect as she could not identify the family.

3.2.30. The children were subject to a case conference. The case has since been closed to Children's Services although there are apparently tasks and timescales that appear to be ongoing. The Children's Services auditor describes a lack of joined up thinking and a lack of analysis in this case.

3.2.31. From the limited information available and from the Children's Services auditor's comments the risks from the baby's father were not assessed. It is unclear therefore what would happen if he wants contact with the child and what if he resumes a relationship with the mother?

3.2.32. It is also unclear what work was been done with the siblings in terms of the impact of domestic abuse. The summary that accompanied the completed questionnaire suggests that the children have a loving relationship with their mother and extended family. The Children's Services auditor however, suggests work was not done with the mother to help prevent her

[6] Ofsted, 2010, The voice of the child: Learning lessons from serious case reviews.
[7] Munroe, E. 2012. Progress Report: Moving towards a child centred system.

forming future abusive relationships and to gauge her understanding of domestic abuse and its impact on children.

3.2.33. In Cases 1, 2 and 3 there appears, from the information available, to be no specific assessment of the risks the father poses other than that the couples have separated.

3.2.34. The Survey Monkey summary for this audit reveals 48.4% said fathers and extended family were engaged in the assessment, 16.1% said they were not, and 35.5% did not know.

3.2.35. There appears to be an overly optimistic view based on parental separation and the mothers' level of cooperation. The risks associated with domestic abuse need to be carefully risk assessed as does the impact on the children which can be long term. This audit suggests that more work is needed with practitioners to ensure their assessments of the risk associated with domestic abuse are fully informed by the evidence available and that they reflect the latest research and the child's development. This will be reflected in a recommendation.

3.2.36. Assessments, when considering the voice of and outcomes for the child, need to be clearer about potential long term impact. Most assessments in this audit only detailed the immediate and short term improvements.

3.2.37. The Children's Services auditor states that most of the work with the family in Case 3, took place over the telephone, a similar comment is recorded in relation to Case 5, where it states there are a lot of notes referring to phone calls and emails and only two visits, one to the home and one to the school.

3.2.38. Direct observations of children and their interactions with others, direct work with children, listening to children and taking into account their perspective and daily lived experience cannot be done over a telephone.

3.2.39. Case 4 concerned an allegation of sexual abuse to a child, which the child made to nursery staff. The nursery followed the correct procedure and a Section 47 (S47) investigation, which included a sexual assault medical assessment, took place.

3.2.40. The Health Visitor in Case 4, observed mother's interaction with the child, her observations around the child's feelings towards the death of a baby sibling are recorded, and the home environment and the child's development was assessed. Regular visits by the Health Visitor have taken place to the home.

3.2.41. There was apparently no medical evidence of sexual abuse. This fact however, does not mean sexual abuse had not taken place. It is assumed that the child is less than five years of age so making such an allegation is a concern in itself. There is no suggestion that the child had any other unmet needs.

3.2.42. The assessment appears to focus on the sexual abuse allegation and to be rooted in the S47 investigation. Given that mother has mental health issues and there has been a death of a baby in the family, a more holistic assessment was warranted. It is unclear if there was a risk assessment of the step-father. The summary that accompanied the questionnaire states the family are no longer together.

3.2.43. The police questionnaire did not detail their involvement in the S47 investigation and forensic assessment, whereas the mother in her feedback felt the police worked well and kept her informed. The mother felt communication was a big issue in this case.

3.2.44. Case 5 was a primary school aged boy who had moved into the area to live with his Grandmother this was because of his aggressive behaviour and early offending behaviour and problems with a busy household.

3.2.45. The school appear to have done a thorough piece of work using one-to-one discussions so the young person could express his feelings and views and they gave him the opportunity and support to attend the CIN meeting.

3.2.46. According to his Grandmother the young person was referred by the G.P to the Child and Adolescent Mental Health Services (CAMHS) who feel he may be on the autistic spectrum.

3.2.47. The Youth Engagement Service (YES) is involved as the young person is subject to voluntary intervention under the youth caution scheme. They are aiming to reduce the level of Criminal Justice Intervention and in doing so reflect his age, maturity, and that he did not have any previous history of offending.

3.2.48. Children's Services contacts were mainly telephone and emails which have been discussed previously (see paragraphs 3.2.37 and 3.2.38). The case was closed to Children's Services after three months with no CAF being deemed to be necessary. The school felt the reason for no CAF was that they were the only agency involved and there were no unmet needs; clearly this was not the case. The YES escalated their concerns about the closure due to the instability of the placement.

3.2.49. To have no CAF is concerning because there is no reviewing process and there are risks regarding his anger, his offending behaviour, the stability of his placement, his wishes and feelings and the need for contingencies. If he has autistic tendencies then his Grandmother's ability to meet his needs will need to be explored. She is already saying, as part of this audit, that she needs strategies to help him along. There is therefore a risk that this case will have to be stepped up in the future because the step down seems to be premature.

3.2.50. The Grandmother feels let down as everyone dropped out and only the YES were left. The Grandmother feels he is not at risk but he is a child in need.

3.2.51. When making assessments sound judgements are needed about the child's needs and the parenting capacity to meet those needs and then clear decisions about how best to address them.

3.2.52. Case 6 concerned children who were being neglected. There was not a complete set of questionnaires covering all the children.

3.2.53. The School Nurse in Case 6 appropriately used a moods and feelings assessment tool with one child and she was able to identify the need for a CAMHS referral.

3.2.54. CAMHS used tailored therapy sessions with the young person and the service describes its performance in assessing the voice and perspective of the child as outstanding. CAMHS were not invited or aware of the multiagency meetings and therefore did not attend initially – they raised this issue with Children's Services and attended meetings afterwards. Specialist

assessments are a critical part of the combined assessment and must inform analysis and plans.

3.2.55. There are a large number of children in this family and each should be assessed individually. The Children's Services auditor felt there was room to bring the individual child's daily lived experience more to life. The Social Worker was inexperienced in this case and had reportedly received no supervision within required timescales. It is clear from the comments of other partners that there had been several changes of social worker.

3.2.56. Partner agencies report improvements in the children as a result of the interventions, and they give the impression that agencies worked well together.

3.2.57. The school in Case 6 have clearly assessed the outcome for one of the children they say the young person is now able to manage her emotional health independently in school and no longer accesses the learning mentor for safeguarding support. School also note an improved relationship between the mother and the young person, and there are more open lines of communication. The School Nurse also comments on an improvement in school attendance, the completion of direct work and an improved relationship with her mother.

3.2.58. Working Together (2015)[8] highlights that every assessment should be focused on outcomes and deciding which services and support to provide to deliver improved welfare for the child, the impact of these services should be used to inform future decisions and actions.

3.2.59. Case 7 concerned a four year old child who had been exposed to domestic abuse. In this case there were several changes of Social Worker and the case was unallocated for some time and as a result some meetings did not take place.

3.2.60. A risk assessment had been completed although the Social Worker had not undertaken any direct work with the child as would be expected given the child's concerning experiences.

3.2.61. The Health Visitor used the Ages and Stages questionnaire as a tool to inform her assessment of the child's development in Case 7 and has observed and recorded the child's emotional and physical development.

3.2.62. The Health Visitor is reported as having highlighted her concerns to Children's Services, on a number of occasions, about the number of changes of Social Worker and that meetings were being cancelled.

3.2.63. Ofsted (2010)[9] commented that a common theme when workers change is the tendency to start again and not give sufficient weight to what had already been known about families. Starting again causes unnecessary delay in meeting the needs of the child.

3.2.64. The Health Visitor is Case 7 pointed out, when step down was about to take place, that outstanding work needs to be completed, the outcome of which is necessary to inform agencies regarding what action is needed in order to meet identified needs. The case was stepped down and this will be discussed later in the report.

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[8] Department for Education, March 2015 "Working Together to Safeguard Children": A guide to inter-agency working to safeguard and promote the welfare of children.

[9] Ofsted, 2010, The voice of the child: Learning lessons from serious case reviews.

3.2.65. The mother in Case 7 commented as part of this audit that the Health Visitor stood out from the rest.

3.2.66. In Case 8 there were concerns for the baby based on historical information – three children had been adopted and one fostered due to mother's parenting and her relationship with a sex offender.

3.2.67. The Social Worker made a good assessment and a timely response. This view was echoed by the Safeguarding chair.

3.2.68. Munroe (2012)[10] talks of proportionate assessments, in some cases a brief assessment is all that is required before services are offered whereas others require more depth, a broader scope and clearly take longer to gain a good enough understanding of the child's needs.

3.2.69. The Health Visitor and Midwife were equally thorough and timely in their assessments. The Health Visitor used the child development attachment checklist which is very useful when a child cannot vocalise and this was coupled with observations of the child and interactions. The Health Visitor also used a screening tool on mother in order to assess her mental health.

3.2.70. The risks were clearly assessed which related to mother's history and her new relationship with the baby's father and the risk of taking the baby abroad to see him, he has controlling behaviour.

3.2.71. Agencies felt Case 8 worked well.

3.2.72. When looking at all the cases, the survey asked whether historical information had been analysed to inform future plans 36.4% said yes, 24.2% said no, and 39.4% did not know. Historical information contributes to an emerging picture so that current events and needs can be understood. As highlighted in relation to Case 1, the fact that the family had had years of social care involvement is highly significant when predicting the sustainability of short term progress. The Ofsted, Nov 2014, Progress Inspection Report to CE, raised concerns that there was a lack of analysis of historical information to inform plans and this audit also supports the need for improvement in this area.

3.2.73. When asked in general within the audit, if the plan had improved outcomes for the children, 33.3% said yes, 18.25% said no and 48.5% did not know.

3.2.74. Previous Ofsted reports into Serious Case Reviews have shown that none of the main agencies had a complete picture of the child's family or a full record of concerns. Lord Laming (2002)[11] recommended that every social care record had a properly maintained chronology.

3.2.75. Walker et al (2003)[12] highlights that a chronology of significant events contributes to the practitioners understanding of the immediate and cumulative impact of events and changes upon individuals within a family and therefore informs decision making. The use of chronologies should inform planning, interventions and the approach to assessments. Practitioners at the workshop recognised the need to agree a combined chronology.

[10] Munro. E., 2012, Progress Report: Moving towards a child centred system.
[11] Laming, 2002, The Victoria Climbie Inquiry.
[12] Walker et al, 2003, Write Enough : Effective recording in Children's Services

3.2.76. The use of chronologies within single agency files was reported as 68.8%.

3.2.77. The audit was not sensitive enough to tease out how collective use of chronologies had informed decision making. In Case 2 for example the disengagement of the young mother with the Social Worker and the Family Nurse needed to be mapped together. The point being made is if both workers were being denied access to the child during the same time period, the risks potentially would be very high given the history.

3.2.78. Practitioners at the workshop felt there was a benefit to having a reflective meeting of professionals only, where they could agree the chronology, evidence and challenge the improvements noted, and agree a plan with contingencies prior to stepping down interventions. Strategic leaders, with some reservations, were generally in support of this approach.

3.2.79. The need for multiagency standards will be reflected in a recommendation.

3.2.80. Whilst some of the cases mentioned are newly registered with a particular G.P, it was good to note that the G.P practices concerned regularly discuss Child Protection, Children in Need and CAF cases with the Health Visitor.

3.2.81. The ability to critically analyse the evidence about the child and family and to make well evidenced decisions and recommendations are essential skills. Supervision helps professionals to maintain a focus on the child, it supports professional's to reflect and enables supervisors to support and challenge staff when developing and revising plans.

3.2.82. Munroe (2012)[13] states that critical appraisal of the assessment and planning for a child and family should be seen as central to good practice in reducing error, and that supervision is the context in which this should happen.

3.2.83. The audit asked if the practitioner received regular supervision. The numbers were worryingly low in the audit, 29% said yes, 51% said no, and 19.4% did not know.

3.2.84. When the audit was analysed in more detailed it revealed that none of the social workers had apparently received supervision in the required timescale, two cases had had management oversight. It is possible; however, that this finding does not reflect evidence contained in separate supervision files. Children's Services have responded immediately to this feedback and will be seeking further clarification to inform their current work in this area.

3.2.85. Supervision is so critical to helping staff make safe decisions that it will be reflected in a recommendation.

3.2.86. Well-kept records assist others to understand and manage the risk and to avoid drift in managing a case. They prevent new workers starting again and wasting valuable time in protecting children. The audit demonstrated that 91.7% of notes reviewed were judged to be very good or fairly good.

3.2.87. In Case 1, minutes had not been scanned into the G.P notes, meaning they were not up-to-date. The surgery is undertaking a significant event analysis of this finding. Of note the strategic leads for the Police and G.Ps pointed out that they are not routinely told about CIN

[13] Munroe, E. 2012. Progress Report: Moving towards a child centred system.

cases. Both services have codes that can be used to inform any future contact with the child and family – they feel this is a real gap in information sharing.

3.2.88. There were some encouraging reports from schools and health staff about the quality of their records. In Case 6 for example the school talked of how they analysed their timeline and chronology relating to the young person and their siblings prior to the meeting in order to identify risks, patterns and trends and this informed the profile of need.

3.2.89. What did feature as an issue within this audit, was the failure or slowness to circulate action notes from CIN meetings; this was most noticeable in Cases 2, 6 & 7. In Case 7 for example the school talk of keeping their notes up to date as no official paperwork was received. Good record keeping should be standard practice for all agencies in attendance at meetings but if you were not invited or did not attend this is an issue; this risk was highlighted particularly for G.Ps.

3.2.90. The Police auditor made repeated comments that there was no rationale for stepping down in the paperwork received.

3.2.91. There is a challenge here as each CIN meeting should routinely result in plans being updated and developed as a result of changing need. However sharing of an up to date plan is required in order to achieve this. When discussing stepping down from child protection to CIN there was no concerns about this process. The concerns relate to the robustness of the CIN process thereafter, this should include circulation of action notes and the updated plan, and regular meetings.

3.2.92. Only 26.7% said CIN meetings analysed progress against the plan, this supports the finding reported in the Ofsted, Nov.2014, Inspection Progress Report.

3.2.93. Practitioners at the workshop and the Strategic Leaders want to see a plan, which focuses on outcomes and evidence; being written and circulated at the time of the meeting.

3.2.94. Practitioners also want local Working Together meetings to be strengthened to help build relationships and to provide a forum to discuss issues/cases. Strategic leaders from health talked of the existence of these meetings however not all agencies attend. If this was to be established as part of a CESB set of standards, attendance needs to be monitored and reported upon.

3.2.95. The issues raised about the CIN process will be reflected in a recommendation.

3.3 Planning for the child and family.

3.3.1. In Case 1 the plan had milestones in place but review dates and the names of people responsible for meeting the actions were missing and this makes measuring progress difficult. The G.P auditor stated that there were no measurable milestones. The Children's Services auditor felt the plan lacked robustness.

3.3.2. The auditor reviewing school nursing involvement commented on the fact that there had been a number of changes of worker in health and social care and some meetings were used to update new professionals and this may have led to delay in the plan and allowed the mother to take over meetings with how she feels about the process. This is a concerning comment and shows how the focus on the child and their needs can easily get lost.

3.3.3. The planning in Case 1 does appear to have improved the outcomes for the children certainly in the short term. The question is whether this will be sustained; families may also feel that when they have made some progress they are being passed around services.

3.3.4. In Case 2 the parents' had separated, there was no contact, there were no concerns about mother's care and therefore there was a limit to the actions in the plan. However there were gaps in the risk assessment about mother's disengagement and no domestic abuse risk assessment. The Children's Services audit commented that the case needed to be managed and progressed in a robust manner.

3.3.5. In Case 2 both health and police had recorded that the plan included that the father could not have contact until he had undertaken a perpetrator programme, they do not specify how this will be achieved or monitored. The lack of specificity and consequences has been a feature in national audits by Ofsted.

3.3.6. In Case 3 the last plan does indicate tasks and timescales however some of them appear to be ongoing and the case has been closed to Children's Services. There are no questionnaires from relevant partners in this case to assess how safe this plan is.

3.3.7. In Case 4, as discussed earlier the focus was on the allegation of sexual abuse and no further actions were deemed to be necessary. There was a gap in planning by not ensuring the mother's mental health was assessed and any risks from the stepfather were not reported upon.

3.3.8. In Case 5 the Children's Services auditor says a plan is in place but it was created as the case was closing and was for other agencies to act upon. As detailed in the assessment section there is no reviewing process in place for this child and it is unclear if agencies are aware of the actions drawn up by Children's Services or if they agree with them based on their assessments.

3.3.9. Case 6 involves a lot of children who have suffered neglect and there was evidence of improved outcomes as a result of the interventions. The plan in this case talks about all the children in general and it is important that each individual child's needs are addressed specifically.

3.3.10. In Case 7 there is apparently no update or review of the plan on the Children's Services file. The case was stepped down to CAF with several outstanding actions. CAF is a voluntary process and it could be argued that if actions have not been achieved under CIN they will not be achieved under a CAF. It is unclear whether the outstanding actions would have a direct impact on improvements for the child.

3.3.11. Plans should set out what services are to be delivered, what actions are to be undertaken by whom and for what purpose. In this case the consequences of not achieving the actions were clearly not explicit.

3.3.12. Parents receiving a copy of a plan or attending a meeting where the consequences of an action not being completed are not explicit will be unclear about what is expected of them and may minimise the risks.

3.3.13. In Case 8 the assessment, planning and step down process worked well.

3.3.14. Ofsted (2014)[14] states where plans were of better quality they; were regularly updated, comprehensively addressed all issues identified through assessment, explicitly addressed how neglect would be addressed, focused on both parents and children and contained clear and specific actions and realistic timescales.

3.3.15. In three of the cases meetings had been cancelled. Plans need to be reviewed regularly to analyse whether sufficient progress has been made to meet the child's needs and on the level of need faced by the child. Plans are reviewed and refined at meetings and should set clear and measurable expectations for the parents with measurable, reviewable actions for them.

3.3.16. The audit summary says that 74.2% felt the plans were clear, 51.9% felt they were outcome focused and SMART, 59.3% felt they were updated at meetings as a result of changing needs and 64.3% felt they focused on both risks and the child's needs.

3.4 The step down process in action.

3.4.1 Apart from Case 8, each of the cases had some gaps in assessment and planning which potentially increases the risk of cases needing to be stepped back up in the future.

3.4.2 There have been questions raised in this audit about the robustness of the CIN process which has to be a consideration in step down decision making as it may make professionals feel less confident in the process.

3.4.3 The audit summary states that 66.7% agreed with the case being stepped down, 8.3% said they disagreed, and 25% did not know. It also revealed that escalation did not take place in these cases.

3.4.4 Following a closer inspection of the written detail in the questionnaires, it shows that in Case 7 the school was unaware that the case had been stepped down until undertaking this audit so they were not in a position to challenge, and in Case 5 the Youth Engagement Service did challenge but it is likely that the case had already been closed. Nevertheless some agencies clearly were disapproving of decisions although this was not formally escalated.

3.4.5 Practitioners at the workshop raised concern that the decision to step down from CIN has been frequently made prior to a meeting taking place and they found this unacceptable within a multiagency process.

3.4.6 The Police consistently comment in their questionnaire returns that there is no written rationale for the step down. When asked in the audit whether the contingencies were clear 28.1% said yes, 25% said no and 46.9% said they did not know. This raises questions for future assessments of risks and needs. Professionals and families need to be clear what would happen should concerns emerge again.

[14] Osted,2014, In a child's time: Professional responses to neglect

3.4.7 Case 1 was stepped down from CP to CIN. There have been some immediate and short term improvements following the separation of the parents. Mothers long history of social care involvement and concerns about her parenting capacity and mental health, the impact of domestic abuse on the children, and lack of a domestic abuse risk assessment involving both parents all mean that a robust CIN plan will be required for some time to ensure any improvements noted are sustained.

3.4.8 Case 2 was stepped down from CP to CIN. This case was discussed at a Multiagency Risk Assessment Conference (MARAC) and the risks from the partner were significant. Mother is a young first time mother who met the criteria for the Family Nurse Partnership's intensive visiting programme. The step down was based on the parental separation and there being no concern about the mother's parenting capacity.

3.4.9 Prior to the decision to step down a domestic abuse risk assessment had not apparently taken place. This would have been expected as part of the MARAC process and it may be that this information is missing from the audit. There was evidence of mother disengaging, and a plan that father had to attend a perpetrator programme before contact with the child, this would then be supervised by maternal Grandmother. A robust CIN plan will be required to monitor the sustainability of this plan.

3.4.10 Case 3 was stepped down from child protection to closure by Children's Services. There is to be no contact between the parents. The children have suffered the impact of domestic abuse, there appears to be no risk assessment of the father and no work undertaken with the mother. It is unclear what the impact of the domestic abuse has had/will have on the children. It appears the plan is ongoing although the case is closed. This decision seems, on the basis of the limited information available on this case, to be premature.

3.4.11 Case 4, was stepped down from CIN to closure. This case involved an allegation of sexual abuse of a young child; the child had no other unmet needs. There was no medical forensic evidence to support the allegation. Mother had separated from the step-father. Mother has mental health problems. There had been a child death in the family. There was no risk assessment completed relating to the step-father and services for the mothers mental health were not followed up. The lack of completeness makes the decision feel premature.

3.4.12 Case 5 was stepped down from CIN to closure. The young person, of primary school age, had moved into Cheshire East from outside the area. He had aggressive behaviour and had begun offending. The case was felt not to require a CAF following a meeting in school as only school were to be involved and because progress had been made since he moved to Cheshire East, which was four months earlier. The Youth Engagement Service and CAMHS are involved and the young person may be on the autistic spectrum. There is no reviewing process in place. Grandmother wants support with strategies to manage his behaviour and there is concern about the stability of this placement. The closure seems premature with a high risk of it needing to be stepped up in the future.

3.4.13 Case 6 was stepped down from CP to CIN the children had suffered neglect. The family have engaged well with the CP plan and professionals, and improved outcomes for the children are being noted. The needs can be continued to be addressed under a CIN plan, the plan needs to look at each individual child's needs.

3.4.14 Case 7 was stepped down from CIN to a single agency CAF. The four year old child was exposed to the domestic abuse. A risk assessment had taken place, the parents had separated and step down was felt to be a natural progression. The Health Visitor questioned the timing of the step down as there was outstanding work in the plan with no evidence that this had improved. No direct work had been completed with the child.

3.4.15 Case 8 was stepped down from child protection to CAF. The baby's half siblings had been removed from mother's care because of historic concern about her parenting and her relationship with a convicted sex offender. The assessment and plan were timely and proportionate and all involved felt the step down process had worked well.

3.5 Challenge and Escalation.

3.5.1 It is clearly important that when the needs of children and families no longer require statutory intervention that cases are stepped down safely and children and families receive coordinated support. Professionals working together to achieve this aim need to have the confidence if they feel decisions are being made prematurely.

3.5.2 The CESB is responsible for producing a threshold document, and cases that are stepped up and down are an illustration of how this threshold is being applied in practice. The decision to step down is a multiagency decision. Multiagency challenge and escalation is therefore a requirement of professionals involved in safeguarding children.

3.5.3 This audit raises questions about of whether the partnership has a shared understanding and a set of agreed standards concerning what is expected in assessment and planning processes in order to ensure services for children are not stepped down prematurely.

3.5.4 The main reasons for concern about the decisions to step down in this audit were some incomplete assessments and some overly optimistic views based on immediate and short term improvements. It was too soon to measure sustainability of the progress made in some cases and therefore a need to have a robust planning process was critical.

3.5.5 The concerns regarding the robustness of the CIN process have been discussed earlier. Practitioners at the workshop also felt that waiting times for services greatly effects the decisions to step down; they listed some services that worried them the most. The partnership needs to be very mindful of this issue.

3.5.6 Partner agencies went along with some decisions to step down that appear to have some premature aspects. It seems that in some instances staff were focused on the improvements they had seen in the child that they were involved with as opposed to a more holistic view that draws on best evidence and research e.g. around domestic abuse. This raises questions about knowledge and experiences in risk assessment across the partnership.

3.5.7 The Health Visitor in Case 7 expressed her concern about the decision that the case be stepped down to a CAF when there were outstanding actions that had not been achieved under CIN. The Health Visitor had been the consistent professional involved in this case and presumably felt best placed to analyse the current risks and needs. Step down happened anyway and it is unclear whether the Health Visitor eventually agreed or whether she went a long with a decision that she was unhappy with without taking it further.

3.5.8 There were a couple of occasions where partners believe they have challenged and escalated concerns, for example the Youth Engagement Service challenged the decision to close Case 5.

3.5.9 In Case 2 the Family Nurse raised concerns with her manager about the number of social workers that had been involved in the case, that meetings had been cancelled and a new partner was in the household. This was escalated to Children's Services. The Family Nurse Partnership Manager needed to have a set of expectations and timescales for her concerns to be dealt with; it is unclear what the outcome was in this case other than to raise the concern.

3.5.10 Practitioners at the workshop and the Strategic Leads felt confident that they resolved issues at a lower level where possible and this is always their intention. The importance of establishing relationships, having consistent workers and the opportunity to meet regularly together for learning purposes makes this much more achievable.

3.5.11 The CESCB's - Resolving professional disagreement procedure (2014)[15] has many steps which will take time to achieve. Staff and their managers need to be confident in the continuum of need and the effectiveness of the escalation process and this will be reflected in a recommendation.

3.6 Other sources of data.

3.6.1 Information has been gained from; talking to families involved in the cases that were subject to this audit, running a workshop for practitioners and by speaking to Strategic Leaders from across the partnership. Where appropriate their feedback is included in the main body of the report and is therefore not replicated in full in this section.

3.6.2 Four of the families (Cases 2, 4, 5 & 7) who were subjects in the audit gave their feedback. In order to be sensitive to their identity the feedback will not be linked to the specific case in this part of the report. The key points of relevance to the step down processes are as follows:

- Three of the families felt agencies had worked well together to support them and ensure the best outcome was reached.
- In one case mother felt she was clear about the plan and received all the minutes, she understood everything as the plan was stepped down.

[15] CESCB,2014 : Resolving Professional Disagreements.

- In this case mother did not welcome the intrusion but could now see it was a "blessing in disguise".
- In two cases the mother said the Health Visitor stood out, one because she saw her more often and another because she sorted things out.
- In another case mother said she was kept informed by the Police and not the Social Worker. She felt left out of the loop. She knew there was a plan but it was not written down. She did not receive minutes and when she did they were full of errors.
- Mother felt in this case that communication was the big issue. However she understood why the case was being stepped down and felt that was the right decision.
- In another case mother felt there was nothing wrong with CE it was the area where the child had come from. A number of things had helped the case partly because agencies are working together.
- In the same case the current carer said the plan was clear at the beginning but then she felt let down as everybody dropped out and she felt left on her own. She did not understand this would happen when the case was transferred from the other area.
- Paper copies of meetings were received after a week or two.
- In another case mother said meetings were held and there was a clear plan. Paper copies of the meeting came after the case was closed to CIN. Out of about 7 CIN meetings the Social Worker did not turn up for half of them.
- In this case mother could recognise that the support had "changed her life and the life of her child for the better".
- In this case mother felt agencies had done a good job and she does not feel they could have improved anything else for her.

3.6.3 The practitioner workshop was very well attended by all agencies. There was a good atmosphere and a genuine desire to continue to strengthen arrangements and jointly own the process.

3.6.4 When discussing the biggest challenges when planning to step services down the following were the key points:

- Agencies believe that in many cases the decision to step down from CIN has already been made by the lead agency.
- Process overrides practice in the decision to step down.
- Supervision not being as regular as it should be for some staff.
- Engagement of families.
- It can be some time before you get the minutes and then only becoming aware of the decision to step down sometime later, leading to different notes/perceptions from different agencies. Those not in attendance do not get the minutes.
- Sometimes the full/collective chronology is missing.
- Issues around: roles, responsibilities and relationships.
- Service waiting times – NSPCC, mental health, FSW in Congleton area.
- Agencies not being aware of the Family Information Service directory.
- The escalation process is too lengthy with too many steps.

- Avoidance in taking responsibility of a CAF.

3.6.5 When discussing what they would like to see in terms of multiagency standards, challenge and escalation some of the points included:

- That professional's need to know when and how to step down.
- Establish a professionals' only reflective meeting to take place prior to step down.
- That an appropriate specialist assessment is completed prior to step down to demonstrate change e.g. neglect graded care profile, CSE screening tool, RIC tool, drug and alcohol tool.
- To have one sheet of paper for the plan, and plans need to record and evidence impact of actions.
- To improve the timeliness of circulation of notes and to agree who the notes need to go to.
- Improve communication and the timely sharing of information. A Police pilot re: sharing domestic abuse information directly with schools was cited as a good example.
- Strengthen local Working Together forums that include G.Ps, Social Workers, mental health etc.
- Simplify the escalation process.
- Where there are changes in staff – make sure you are up to date before the meeting.

3.6.6 The emerging findings from the audit and the views of practitioners were shared with seven strategic leaders from across the agencies. The following is a summary of some of the key issues raised:

- There was recognition from Health and Education Leaders of the workload pressures in Children's Services and their understandable need to focus on far more serious cases which may have resulted in not following through some issues before stepping down.
- All partners acknowledged the work that is being done in Children's Services to address the staffing, supervision and workload challenges. The Children's Services lead was very open about the challenges explaining that the high number of CIN cases that were needing to be stepped down may have resulted in some of the points raised and going forward getting the basics right is crucial.
- There was recognition of the need for meetings to continue if the Social Worker was unavailable however they felt this could only been done safely if an up to date plan was available. The drift associated with cancelled meetings and late circulation of notes was a concern for Education and Health Leads.
- The Health Leads felt that the CIN process was too loose particularly when the children may still be in considerable need. Health and Education leads felt the opportunity for staff to meet without the parents was important in complex cases in order to evidence improvements and challenge each other prior to deciding to step down.

- The Children's Services Lead had some understandable reservations about professional only meetings, whilst fully appreciating what staff were saying.
- The frustration of poor feedback on cases was an issue for Education and Health. An Education Lead spoke very highly of the Police Operation Encompass, where the Police notify school of domestic abuse incidents when children are part of the family.
- The Detective Superintendent (Det. Supt.) was not sighted on the particular issues raised in this audit however the Police willingness to share information about cases lower down the continuum, if there were concerns about a child's welfare, was apparent and this position will be strengthened further with the new national guidance.
- The Det. Supt. and G.P Lead both recognised that information about cases where children were subject to CIN is often not known unless they were stepped down from CP. Both services have codes that would highlight a CIN on their systems and this lack of information is a significant gap.
- The G.P Lead also shared another communication challenge and risk when G.P practices are on the borders and Health Visitors are from other Local Authority areas. The usual good practice meetings with Health Visitors and G.Ps do not take place with the Health Visitors from outside CE.
- The Police, Health and Education leads all felt the plan for the child and family should be drawn up at the meeting and circulated there and then and its focus should be on the outcomes and how they will be evidenced.
- Education Leads have recognised an improving situation in Macclesfield with consistency of Social Workers. This was clarified by the Children Services Lead; there are no Social Work vacancies in Macclesfield whereas there remain challenges in Crewe with a need to use agency staff.
- The Children's Services commitment to, and the work around supervision of Social Workers came across very strongly; further exploration and sense making of the supervision findings will be made.
- All the strategic leads recognised the need to provide help earlier, and the need to engage families' pre CIN.
- The importance of good relationships between staff was recognised by all and there was general support to strengthen working together learning lunchtime meetings in local areas.

Section 4: Conclusions

4.1 Summary of findings

This audit has highlighted, when making decisions to step down interventions, the importance of the essential building blocks of detailed and proportionate assessments, reflective analysis which is informed by historical information and underpinned by best practice and research, and planning that is focused on evidence of improved outcomes for children.

All agencies were able to demonstrate good performance in the way they ensure a child's voice and perspective influences service delivery, and in some cases the improved outcomes that had been achieved for children were clear to see. Partner agencies showed commitment to attending multiagency meetings and there were reports by auditors and parents/carers of some effective multiagency working.

There were concerns about the robustness of the CIN process which were identified in the audit and these findings were then confirmed by practitioners at the workshop; this is an important context when considering if the step down of interventions for children has been premature. In some cases the decision to step down was a single agency decision. There was also concern about the number of cancelled meetings and the absence of minutes and up to date plans. Practitioner's also felt waiting times for some services was an issue.

Practitioners were able to identify some simple steps that could improve multiagency ownership of the CIN process in order to ensure that decisions were as informed as possible.

The importance of regular supervision, good record keeping, and effective information sharing cannot be overstated and this audit has highlighted that in some instances practice in these areas fell below expected standards.

In the Author's view, and based on the information available for analysis, there were a small number of cases where the step down of interventions had taken place prematurely.

There was some evidence of overly optimistic and early judgements about the improvements that had been made in the absence of any evidence to show that consideration had been given to sustainability or that there were clear contingencies should these improvements not be sustained.

Whilst this audit focused on the stepping down of interventions, the way in which cases are stepped up the continuum is also relevant. This audit, and the discussions with practitioners', has highlighted the ongoing need to ensure thresholds are fully understood and applied in a multiagency manner, and that staff and their managers are clear about their role in challenge and escalation if this was necessary.

In this audit sample half the cases involved children who had suffered as a result of domestic abuse. The questionnaire was not sufficiently focused on this theme so there are questions that are not sufficiently addressed about the use of appropriate risk assessment tools and the sustainability of decision making. The management of domestic abuse requires a specific audit.

Section 5: Recommendations

- ## Recommendation One

In order to ensure an increased focus on managing the risks associated with domestic abuse – CESCB to include the findings of this audit in designing the next multiagency audit on domestic abuse.

- ## Recommendation Two

In order to ensure that decision making in the application of the threshold to step down services is fully owned and understood by the partnership – CESCB to consider establishing a set of multiagency standards which include a strong emphasis on: Examining the evidence that a child/young person's needs have been met, that any improvements are felt to be sustainable, and that there are contingencies in place; before a final decision to step down is taken.

- ## Recommendation Three

In order to be assured that staff are in a position to make safe, supported and sufficiently challenged decisions to recommend the step down of services – CESCB to seek assurances from Children's Services and partners, that supervision is meeting their current requirements with a view to developing a set of multiagency supervision standards.

- ## Recommendation Four

In order to ensure safe arrangements are in place for children when services are stepped down – CESCB needs to develop a greater level of assurance and identify actions to ensure the CIN part of the continuum of need is working effectively in relation to active case management, information sharing and workflow.

- ## Recommendation Five

In order to ensure that professionals know how to escalate concerns and that the process is fit for purpose – CESCB need to place continued emphasis on ensuring that all frontline staff and first line supervisory staff in the children's workforce, have a current understanding of the continuum of need and the escalation procedure.

Appendices

Appendix 1: CESCB Multiagency audit tool – step down

Voice of the child and family

Is there any evidence that your agency is meeting their requirements to represent the experience of the child?	Yes	No	Don't Know
Please Provide Details:			

Is there evidence that the collective experience of the child is informing your agency's activity?	Yes	No	Don't Know
Please Provide Details:			

Does the plan and your agency's part in the plan have measurable milestones that reflect observed improvement in the child?	Yes	No	Don't Know
Please Provide Details:			

Taking into account the elements above, please select an overall grade for the performance of the service in representing the voice of the child and family.			
Inadequate (does not meet minimum requirements)	Requires improvement (meets minimum requirements)	Good (exceeds minimum requirements)	Outstanding (significantly exceeds minimum requirements)

Case file recording

Are the key details of the child recorded correctly on the file?	Yes	No	Don't Know

How many visits are recorded from your agency in the last 6 months?			
0	1-3	4-6	7+

Is there a chronology on the child's file? **If yes, is the chronology up to date?**	Yes	No	Don't Know
Please Provide Details:			

How do you rate the quality of the recording?			
Very good	Fairly good	Fairly bad	Very bad
Please tell us the reason for your answer:			

Is there evidence of analysis in the recording?	Yes	No	Don't Know
Please Provide Details:			

Taking into account the elements above, please select an overall grade for the performance of the service in relation to case file recording.			
Inadequate (does not meet minimum requirements)	Requires improvement (meets minimum requirements)	Good (exceeds minimum requirements)	Outstanding (significantly exceeds minimum requirements)

Planning for the child and family

Has your agency attended all relevant meetings in relation to this child and family? If not, please provide details.	Yes	No	Don't Know
Please Provide Details:			

Was there engagement of absent fathers and extended family members?	Yes	No	Don't Know
Please Provide Details:			

Is the plan clear?	Yes	No	Don't Know
Is the plan outcome focussed and SMART (Smart, Measurable, Achievable, Realistic, Timely)?	Yes	No	Don't Know
Is the plan updated routinely at planning meetings as a result of changing needs?	Yes	No	Don't Know
Is the plan focused on both risks and the child's needs?	Yes	No	Don't Know

Are the contingencies clear?	Yes	No	Don't Know

Are roles in the plan clearly identified, including the roles of the social worker, parent/carer, partner agencies?	Yes	No	Don't Know

Did Child in Need meeting groups analyse progress against the plan?	Yes	No	Don't Know

Is there clear evidence that the plan has improved outcomes for the child/family?	Yes	No	Don't Know

Has historical information been analysed to inform future plans?	Yes	No	Don't Know

Please provide additional information about any tools your agency has used to help in the analysis and decision making for the child and family below.

Taking into account the elements above, please select an overall grade for the performance of

the service in relation to planning for the child and family.			
Inadequate (does not meet minimum requirements)	Requires improvement (meets minimum requirements)	Good (exceeds minimum requirements)	Outstanding (significantly exceeds minimum requirements)

Management oversight

How many changes in the lead professional for the family from your agency has there been in the last 6 months?			
0	1-3	4-6	7+

Is there evidence of management oversight of your agency's involvement on the file in the last 3 months?	Yes	No	Don't Know

Does the case worker involved receive regular supervision (every 4-6 weeks?)	Yes	No	Don't Know
If yes, how often was the case discussed in supervision?			
If yes, where is this recorded?			

Have there been any professional disagreements or escalation (formal or informal) of this case (at any level) due to issues between agencies?	Yes	No	Don't Know
If yes, please provide details:			

Taking into account the elements above, please select an overall grade for the performance of the service in relation management oversight.			
Inadequate (does not meet minimum requirements)	Requires improvement (meets minimum requirements)	Good (exceeds minimum requirements)	Outstanding (significantly exceeds minimum requirements)

Step down process

Was your agency involved in the decision to step down?	Yes	No	Don't Know
If not, please provide details:			

What is your understanding of the reason for the plan being stepped down? Please tell us below.

What risks and/or needs were considered in the decision to step down? Please tell us below.

Did your agency agree with the decision to step down?	Yes	No	Don't Know
If not, did you agency escalate this disagreement with the lead agency?	Yes	No	Don't Know
Please provide details:			

Was the voice/daily lived experience of the child evident in the decision to step down?	Yes	No	Don't Know

Was the family aware of the reason to step down this case?	Yes	No	Don't Know

Has your agency any plans to support the child/family once the case has been stepped down?	Yes	No	Don't Know
Please provide details:			

Are there any challenges for you agency as a result of this case being stepped down?	Yes	No	Don't Know
Please provide details:			

Taking into account the elements above, please select an overall grade for the performance of the service in the step down process.			
Inadequate (does not meet minimum requirements)	Requires improvement (meets minimum requirements)	Good (exceeds minimum requirements)	Outstanding (significantly exceeds minimum requirements)

Overall views and final comments

Taking all your answers into account, please select an overall grade for this agency file.			
Inadequate (does not meet minimum requirements)	Requires improvement (meets minimum requirements)	Good (exceeds minimum requirements)	Outstanding (significantly exceeds minimum requirements)

Is there anything within the audit which suggests this case needs to be escalated? Please provide details in the box below.	Yes	No

Are there any areas of practice you feel you work well? Please provide details below.	Yes	No

Appendix 2: A brief overview of each of the cases.

Child 1

The children were made subject to a CP plan 14-May-2013 under category of emotional abuse and the plan ceased 12-Jan-2015.decision made to step down from CP was based on progress being made on the CP plan and change of family dynamics with parents being separated and father being out of the home. Agreement that positive progress had been sustained over review period and recommendation for support to be provided under CIN for minimum of 3 month period.

Child 2

Child became subject to a CP plan on 05.11.2013 under the category of at risk of emotional harm. The concerns related to domestic violence within parents' relationship. Father was deemed by MARAC to be a high risk to partners and anyone who attempts to intervene. Child became subject to a CIN plan in February 2015, following positive outcomes achieved for Ivy on the CP plan. Mother ended her relationship with father and he began having supervised contact with child. Child was thriving; she was attending nursery full time and mother continued to promote children early years and development. This was achieved through mother working closely with Family Nurse Partnership, who spoke positively of hers parenting of child and her ability to not only meet her basic needs, but the emotional warmth she displayed and her want to learn more about child's development. Mother seemed to better understand the emotional impact domestic violence has to children, and therefore Mother did not keep in contact with father, only to drop child off for supervised visits.

Mother engaged well with social care, however there was a period of time (approximately 6 weeks) where social worker had been unable to complete statutory visits to child. Although Mother continued to engage with the social worker via texts and calls, Mother reported either forgetting about social worker visits or the social worker would visit announced and child would be at nursery or grandparents' house. When social worker stressed to Mother the importance of engagement and the implications this can have, Mother began working well with social care again. All professionals agreed that Ivy was thriving and meeting her developmental milestones. There were no concerns regarding Mother's parenting capacity and her ability to actively safeguard child.

Child 3

1 year old, mother in relationship with child's father, 18 month relationship. Volatile from the start. Baby at risk. The Initial Child Protection Conference was convened following an incident in May 2014 where mother was assaulted and sibling was threatened by baby's father.
Bail conditions meant mother and father were to have no contact however conditions were breached and professionals had concerns regarding domestic violence within the relationship and the safeguarding of the children. The children have a loving and warm relationship with their mother and extended family. They also have good avenues of support and enjoy local activities. They have however been exposed to aggression, domestic violence and substance misuse. Sibling has expressed concern over the verbal comments baby's father has made and has presented as fearful of him calling the police on one occasion. Relationship ended and mother engaged with social care. Meeting took place attended by mum, agreed that good progress has been made, no safeguarding concerns, and despite the gap in provision from social care, no role for children's social care and social care can end involvement.

Child 4

Child made an allegation of sexual abuse perpetrated by mother's partner. Out of Hours was the initial point of contact with the child and her Parent (Mother). Child and her Mother moved out of the address they shared with Mothers partner. Medical arranged and child attended. Child and Family Assessment completed. Child in Need Meeting took place. Birth Father consulted with. The case closed down to CSC as concerns not substantiated.

Child 5

Child was open as a Child in Need. He had moved to Cheshire East from another authority under a private arrangement made by the family. Child's parents had found it difficult to manage his behaviour which was often angry and aggressive to family members. Child described this behaviour to be a result of the 'busy house' that he lived in. His previous social worker in Leeds states that his parents would often allow him to play outside until late and that he was spending time with older peers. A child in need meeting was held at school where it was felt that he was making considerable progress since moving to Cheshire and was responding well to the 1:1 support he was receiving from Grandmother (he has 4 other siblings), Grandmother is able to provide better structure/boundaries.

A suggestion for CAF was made at the meeting, however it was felt by the other agencies that a CAF was not necessary at this time. Child currently works with youth support worker due to an offence that he received a caution for. A referral was made to family support however they felt that could carry out the tasks that I had requested.

Child 6

Child was made subject to a CP plan on 22.04.2014 under the category of neglect. Child and her family have received a range of identified support from professionals involved. The family have engaged well with the CP plan and professionals. It was decided that further identified support can be completed under a CIN plan. This was agreed by all professionals involved. Child is due to do further keep safe work and work around legal highs with a FSW under the CIN plan.

Child 7

Four year old child, domestic abuse between mother and partner. Child made subject to CIN plan, which ended The Child in Need plan is no longer required as mother engages well with all agencies and has taken action on all advice given. The family will now be supported under CAF.

Child 8

Baby is now 9 months old, she is the youngest of five children born to mother whose older children are not in her care, 3 are with an adoptive family, but she sees them twice a year, and her oldest child is in long-term fostering and she has contact with her approximately every 2 months.

Baby was made subject to child protection plan on 28th April 2014, so before she was born, the reasons for the child protection plan was primarily due to the historic concerns around mother's parenting and due to her being in a relationship with a male who was the father to three of her children and was a convicted sex offender.

Mother became pregnant when she had been abroad and although she was having a long distance relationship with baby's father, he has not travelled to the UK and their only form of contact was SKYPE. Initially mother wanted to travel to Tunisia to allow father to meet baby, however mother

was advised about the possible health risks to baby and stated that she did not wish to place her at risk and therefore chose not to travel. During the period of child protection mother discussed her thoughts and feelings in relation to baby's father and overtime the relationship came to an end.

During the pregnancy and immediately following birth mother and baby were living with mother's sister and her niece, this was seen as a protective factor in relation to mother having access to support and advice when caring for baby. When baby was around 3 months old, they moved to their own property and it was felt that this would be a significant time for mother to demonstrate whether the positives which had been identified would be maintained when she was not supported by her sister.

During the period under Child Protection mother was co-operative with professionals and she attended all health appointments for herself and baby, Mother demonstrated that she was able to manage her finances and her budgeting, observations by all professionals during planned and unplanned visits were that there was no difference in the home conditions, the day to day care of baby or the presentation of mother.

The Child protection review was held on 16th January 2015 and the outcome was that baby no longer required a child protection plan, that mother's care of baby was to a good standard and that baby did not require any additional support beyond universal services and therefore the health visitor was to continue to support them both.

To note the above summaries were written by members of staff and they have not been altered.

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