

EAST AYRSHIRE CHILD PROTECTION COMMITTEE: 28 OCTOBER 2009

FILE AUDIT RESULTS

1. PURPOSE

- 1.1 To advise the Child Protection Committee of the results of the multi agency CP1 and file audit which was undertaken in August 2009.

2. BACKGROUND

- 2.1 The file sampling group was established to carry out aspects of the self evaluation plan and to achieve the actions identified in the assessing risks and needs action plan. The group has representation from Child Protection Co-ordinator (Chair), Social Work, Schools, Early Years, Health, SCRA, Police (x2) and Housing.
- 2.2 East Ayrshire hosted a Pan Ayrshire training event led by Fiona McManus (HMle) looking at file sampling and the revised quality indicators. A Practice Agreement was approved by the Child Protection Committee, to set out the remit. The group agreed the audit tools to be used for CP1 sampling and a separate tool for file auditing. The audit tool ensured that the actions of the assessing risks and needs action plan would be fulfilled and looked at areas for improvement from the last inspection.
- 2.3 On 4 August 2009 the group audited 9 CP1s and on 12 August 2009 the group audited 4 child's files. It was agreed that auditors would work in pairs to read the files to promote learning and enhance confidence.

3. KEY AREAS FOR AUDIT

- 3.1 The key areas audited were:

- was there involvement of all relevant services in the initial discussions and decisions?
- was feedback to referrers recorded in file?
- were child and families views are sought and recorded in file?
- was there proportionate decision making
 - details of concerns
 - assessment and risk factors
 - recommendation

- how well do we record the reasons for our decisions?
- how well do we assess risks and needs- are there assessments present in files, are they comprehensive, up to date and relevant?

4. THE SAMPLE

4.1 Four files were selected at random, ensuring a range of ages and geographical areas, from the list of children in the HMle Pre Inspection Return Sample. The second theme for selection was that the child had moved into the East Ayrshire area.

5. FILE SAMPLE RESULTS

5.1 Quality Indicator 5.2 information sharing and recording

CORE INFORMATION RECORDED IN FILE

- Consistency of information was generally found across the agencies in all four sets of files. All the records could be easily read, followed and information clearly sectioned/ defined and accessible. It was noted that the education files were the same format as the social work files and questioned whether education files should be designed to fit their purpose.
- Single agency chronologies were in place in the key files except from one health file. A key factor in one set of files was that all agencies chronologies, except health, only started when the child came to East Ayrshire, no information was recorded in relation to the events in the previous local authority area.
- Within the files it is not clear when the information in chronologies are shared with other agencies.
- Three files had evidence of supervision/ line management commenting on and signing off records. One case, which was not child protection, did not.

5.2 Quality indicator 2.3 - children and young people are helped by the actions taken in immediate response to concerns

REFERRALS

- All four sets of files contained evidence of referral being made and clear evidence of information sharing. One contained a referral from a GIFREC meeting. In one instance it was noted the school could have been informed earlier as they only knew of the referral when reporter requested a report.

- Within the sample there were two excellent examples of inter-agency communication at the time of referral. One case initiated extensive information gathering from across Britain resulting in a professional discussion being quickly arranged.
- One file's referral information lacked details of previous involvement in another local authority area; this lack of information had a significant impact upon the initial assessment for the child.
- There was clear evidence of joint decision making, including alternative supports which could be provided to the child. For example, for one child there were clear efforts to manage the risks in the home on a partnership basis and maintain the family unit with multi agency supports.
- Within files there was evidence of clarity of intervention at the time of the referral, including identified inter-agency and single agency responsibilities. Within one child's file there was clear intervention in relation to one referral but no clarity of intervention or reason provided as to why no further action/intervention was taken regarding a referral from nursery to social work that violent man moving into the family home.
- There was evidence of timeous action in relation to the child protection referrals and where appropriate there was evidence of feedback to referrer within the files.

5.3 Quality Indicator 5.2 information sharing and recording

INFORMATION SHARING

- Clear evidence, in all files, of information sharing across agencies with a positive impact on the child and all agencies clearly aware of the risks. Key factor for one child was the lack of information from another local authority area in relation to previous concerns.
- Only one child's sets of files had clear agreement to share information indicated on the file.

5.4 Quality Indicator 5.3 Recognising and assessing risks and needs

ASSESSMENT

- For three sets of files there was clear evidence of assessment based on the child's needs, including evaluation of information and a clear process of intervention, however the writing up of the assessment into a report was subject to delay in one case. For one child the auditor felt, with hindsight, the decision to move to child protection could have been made sooner.

- All sets of files contained a written assessment, but one file had no clear health assessment. Assessment for all four children reflected the views of parents and carers. It was evidenced that the assessment was informed by and understood by other services. Good interagency working was evident but in one case it was unclear from file how other agencies were feeding into the comprehensive risk assessment being completed.
- Re-assessment and ongoing review was evident in all sets of files, however one child had significant changes in contact with minimal reasoning given.

5.5 Quality Indicator 5.4 Effectiveness of planning to meet needs

INTER-AGENCY MEETINGS

- Within three sets of files there was evidence of interagency meetings being requested and actioned appropriately although one child's file noted that core groups were held regularly but a review case conference was cancelled twice due to poor attendance. In one case the minute for a case discussion/conference held September 2008 was missing from files.
- In one child's health visiting file there was no information from the midwives file, therefore information on significant pre birth activity was missing.
- Child Protection meetings had a clear purpose and the minutes reflected participation/discussion by all agencies. It was difficult to comment on LAC meetings as only decisions were in files and not a full minute.
- There was evidence of joint decision making and joint agreement in all files. Decisions were based on the assessment of needs and risk of the child. The reasons for decision were clearly recorded. In one child's file the decision made was based on the information available, this assessment was incomplete due to the absence of information from the previous local authority area

INTERVENTION/PLANNING

- Protection plans or other clearly identifiable care plans were place and each of the child's records reflected ongoing evaluation of intervention and planning. However, in one case a significant review of contact took place with no clarity of reasons for decision.
- Each child's records identified clear responsibilities and a plan supported by joint working. The plans reflect effective processes of intervention and provision of practical supports. However, there was an example of support to parents not detailed, except for contact, and an instance of limited detail of long term planning for a child.
- There was evidence of the plans reducing or minimising risk of significant harm and the files provided information that the plans in place did make a difference

5.6 Quality Indicator 5.1 Involving children and families in need of protection

CHILD /FAMILIES VIEWS

- Evidence of parents/carers participation in meetings and that the views of parents /carers and children were clearly recorded.
- There were no examples of attendance of children at meetings in the sample, this was not highlighted as a concern for the auditors
- In two cases the child's views were clearly recorded in the file, in two cases this was deemed to be not applicable due to age of the child.

5.7 Quality Indicator 2.3 Children and Young People are helped by the actions taken in immediate response to concerns.

- In one case a CPO was taken immediately when the voluntary arrangement for the child's care broke down.

5.8 Quality Indicator 5.4 Effectiveness of planning to meet needs

REASONS FOR DECISIONS

- Reasons for decisions were clearly recorded in case notes, except for the already noted contact decision in relation to one child. Reasons for decision that reflected the assessment of needs and risks.
- In each case appropriate referrals were made to Scottish Children's Reporters Administration.

WHAT DIFFERENCE HAS IT MADE?

5.9 Quality Indicator 2.1 Children and young people are listened to, understood and respected; Trust

- Within files there was evidence of good relationships with support services.

5.10 Quality Indicator 2.4 Children and young people's needs are met

- For all the children it was evident that the interventions and supports in place resulted in some improvement for the child.

KEY LEARNING ISSUES

- If one agency is aware that a child who has come into the area has previously been on the child protection register in another area, it would be good practice to share this information with the key agencies;
- Ensure that when there are pre birth concerns and case conferences at birth that the information from the Midwives file is transferred to the Health Visitor file;
- Ensure that care plans contain long term planning needs
- No children were in attendance at meetings, not raised as a concern but worth further exploration
- For significant changes to the care plan, such as with contact, the reasons for the change should be clearly noted in the file.
- Need to ensure that agreement to share information is clearly recorded in files

RECOMMENDATIONS

- To work with the West of Scotland Child Protection Committee Chairs group and their good practice guidance being developed in relation to transfer of information and children's files
- Revise process of transfer of information from ante-natal stage through to the name health visitor and child's health record.
- Consideration of children's attendance at reviews and how to ensure that we know their views

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CP1 SAMPLE EXERCISE

1. BACKGROUND

- 1.1 The CP1 is the Child Protection Procedures Initial Report form which is completed by the social worker after a child protection investigation.

2. THE SAMPLE

- 2.1 A CP1 audit proforma was agreed by the group and completed for each CP1 audited. The sample was the first multi agency CP1 audit in East Ayrshire and the first time that the audit form had been used.
- 2.2 Nine CP1s were selected at random, ensuring a range of ages and geographical areas, from the list of children in the HMle Pre Inspection Return Sample.

3. KEY ISSUES

3.1 Core Information

- In most forms the key information was recorded (77%), on one CP1 there was key information missing such as time of referral and agencies details incomplete.
- Some issues were identified in relation to the timeline and timescales. More interrogation and discussion is required in relation to this matter. Difficulties arose in looking at whether action was taken timeously as some CP1s had missing information in relation to dates and times.
- Most CP1s referred to chronological history, although not always using the specific term.
- No CP1s referred specifically to the term 'tripartite discussion' although it was clear from the report that there had been appropriate discussions between health and the police. In 2 cases there was no reference to health noted.
- Most CP1s detailed good information gathering from key agencies to inform decision making.

3.2 Views of the Child and family

- Most CP1s (67%) had clear and detailed views of the parents/carers, although 3 CP1s did not contain their views
- 4 CP1s (44%) contained clear views of the child, although not all of these were in a clearly defined section for children's views

- 5 CP1s (55%) did not contain the views of the child, although in one of these the views were implied through the discussion of the report and 2 CP1s related to children under 4 years

3.3 Key information

- all CP1 were factual in content with only appropriate opinions based on evidence expressed.
- all CP1s contained information in relation to the social circumstances /family background of the child, their support network, previous concerns and previous investigations where appropriate. However 2 CP1s did not contain details of contact with all the key agencies.
- all CP1s contained details of the incident but in 3 there was not an explicit statement about the vulnerability of the child.
- Only 1 CP1 did not contain full details of the strengths and weaknesses and one did not contain a clear statement of level of risk.
- 5 CP1s did not clearly enough detail the supports available to the child from specific agencies or possible resource options. Very good details of family supports/resources were given.
- 8 CP1s (89%) the reasons for the decisions and recommendations clearly reflect the assessment of needs and risks of the child. In one report it was not explicit why the recommendation was made or the level of exposure experienced by the child as they lived out with the family home.

4. STRENGTHS

- Clear well written reports, no overuse of jargon
- Good assessments
- Address vulnerability
- Risks and protective factors clearly presented

5. AREAS FOR IMPROVEMENT

- Better administrative details required. Issues were identified in relation to establishing the timeline due to the lack of dates on the CP1s. Need to ensure dates and times are inserted re investigation, completion and signing off of CP1 to enable comment on timekeeping
- Clear statements on views of child and how they were ascertained, suggest to be under its own heading 'views of child'

- Ensure views of parent/carers evidenced on all CP1s
- Ensure contact with health re information gathering and assessment. Only the CP1 was reviewed and therefore it was unclear to auditors whether case files evidenced discussion with health that was omitted from the assessment form
- Ensure that reports contain clear concise information as 2 CP1s were over 18 pages long. These were difficult to read and raised concerns for families ability to read and understand information being presented.
- File audit group to review process undertaken and consider methods of validating process.

6. RECOMMENDATION

- Consideration of review of format of the cp1 to ensure clear section for the child and families views.
- Ensure dates and times are inserted to enable monitoring of timescales.
- Review information sharing to ensure health are included in all discussion.

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