Agenda Item 4.3 (i)

APPENDIX 1

EAST AYRSHIRE CHILD PROTECTON 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 (HMIe) 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 promote learning and enhance confidence.

3. KEY AREAS FOR AUDIT

3.1 The key areas that were to be audited were:

- the involvement of all relevant services in the initial discussions and decisions?
- feedback to referrers recorded in file?
- Child and families views are sought and recorded in file?
- 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 their 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 HMIe 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

- Three files clearly identified the lead professional. In one file the lead was not easily identified. In all files the significant adults were identified.

- Single agency chronologies were in place in the key files except from one case where it was missing in health. A key factor in one file 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. For example, in one case an incident of a violent partner moving into the family home was not shared beyond social work.

- 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.

- Three files had evidence of supervision/ line management commenting on and signing off records. One case, which was not child protection, did not.

- 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.

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. One child's file noted the school could have been informed earlier as they only knew of the referral when reporter requested a report.

- Two children's files had evidence of excellent inter-agency communication at the time of referral. For example, in one file highlighted communication within health to identify the initial concern, then appropriate multi agency information sharing which resulted in a professional discussion meeting within one week of referral.

- 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.

- Within 3 sets of files the records reflect joint decision making, including alternative supports which could be provided to support 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. One file audited deemed this not applicable.

- Two children's files provided 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.

- Where appropriate there was evidence of feedback to referrer within files.

- Where appropriate there was timeous action in relation to the child protection referral was noted for three sets of files. One file audited deemed this not applicable.

5.3 Quality Indicator 5.2 information sharing and recording

INFORMATION SHARING

- All four sets of files provided clear evidence of information sharing across agencies with a positive impact on the child and all agencies clearly aware of the risks. For one child's file there was an issue with information sharing from another local authority area only.

- 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 3 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. For one of the files this was noted as partial due to concern that child protection measures should have been initiated sooner. Within one case good assessment information was contained in individual files but there was a delay in completing the report appropriate report.

- All sets of files contained a written assessment, but one file had no clear health assessment.

- Assessment reflected parents/carers views in relation to all four children, For one child it was highlighted that the views of parents were not only documented but also addressed or reasoning given for not being followed.

- All four children's files evidenced that the assessment is 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. In one case professional discussion was arranged with speed when concerns became apparent and the Initial Child Protection Case Conference took place immediately after birth. For one child minutes were not contained in all files and there was no minute of a case discussion/conference held September 2008, In another child's file it noted that core groups were held regularly but a review case conference was cancelled twice due to poor attendance. In one child's file there was no information from the midwives file contained in health visiting file, therefore missing significant pre birth activity.

- In all files there was clarity of purpose of meetings and the minutes reflected participation/discussion by all agencies. It was noted however that it was difficult to comment on LAAC meetings as only decisions were noted in files as they are not minuted.

- 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. 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

- In all four sets of files the reasons for decisions were well recorded.

INTERVENTION/PLANNING

- Each of the children's file in the sample had a protection plan or other clearly identifiable care plan in place.

- Each of the child's records reflects 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 not just provision of practical supports. However, in one case no details of support to parents were provided except for contact. For another child long term planning needed to take account of carer's health and family situation.

- For all four children there was evidence of the plan reducing or minimising risk of significant harm and information from the files highlight that the plan did make a difference

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

CHILD /FAMILIES VIEWS

- For three of the children's the parents/carers participation in meetings was noted. For one child this was unknown due to lack of a minute of the meeting.

- Whether in attendance at meetings or not the views of parents /carers and children were clearly recorded in three cases.

- Child attendance- there were no examples of attendance of child 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 2 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.

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5.8 Quality Indicator 5.4 Effectiveness of planning to meet needs

REASONS FOR DECISIONS

- In each of the four children's files the reasons for decisions were clearly recorded in case notes, except for the already noted contact decision in relation to one child.

- Each of the child's files had 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 level of 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 Midwifes file is transferred to the Health Visitor file;

- For significant changes to the care plan, such as with contact, the reasons for the change should be clearly noted in the file.

Diane Burns
Child Protection Co-ordinator

APPENDIX 2

EAST AYRSHIRE CHILD PROTECTON COMMITTEE: 28 OCTOBER 2009

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 initial sample was the first multi agency CP1 audit in East Ayrshire and the first time that the audit form had been used.

2.2 Eight CP1s were selected at random, ensuring a range of ages and geographical areas, from the list of children in the HMIe Pre Inspection Return Sample.

3. KEY ISSUES

3.1 Core Information

- In most forms the key information was recorded (77%) although 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 CP1

- Ensure dates and times are all inserted re investigation and completion and signing off of CP1 as otherwise unable to 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.

- Ensure that reports contain clear concise information as 2 CP1s were over 18 pages long which was difficult to read but also concerns for families ability to read and understand information being presented.

- File audit group to review process undertaken and consider methods of validating process.

Diane Burns
Chid Protection Co-ordinator