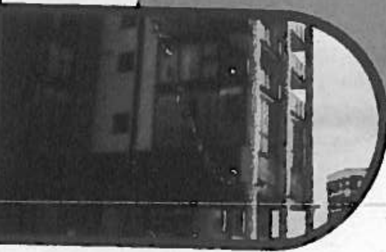
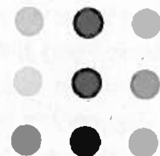
Skylakes Audit Report

July 2013





SANCTUARY
SOCIAL SERVICES PROJECTS

SANCTUARY

1.0 Introduction

1.1 Skylakes is the Social work led delivery arm of Sanctuary Health and Social Care Group providing independent social work services. The service is managed and developed by social work managers who have established their experience within the children's work force across various disciplines. Skylakes' head office is based in Ipswich but it operates services from satellites across the country making the service accessible to over 80 Local Authorities.

Skylakes was commissioned by the Director of the Haringey Children and Young People's Service in June 2013 as an independent agency to conduct a time specific quality assurance review of 400 child records with relevance to the initiation of Section 47 investigations under the 1989 Children Act, following an adverse judgment against the Council in a Judicial Review hearing.

1.2 The High Court's ruling in *AB & Anor, R (on the applications of) The London Borough of Haringey (2013) – Admin EWHC 416 – 13 March 2013* sets the background and context of the audit. Briefly the judgment describes the submission of an anonymous allegation to Haringey's Children and Young People Service and determined -:

a) That there was never a s.47 enquiry decision, implemented.

b) The decision to progress and initiate a S.47 enquiry was unlawful and should be set aside

c) The initial data gathering exercise was unlawful.

As a consequence of the judgement the Director has decided to commission an independent review of S.47 enquiries conducted in the period under examination by the judicial review, between May 2011andMarch 2013 to review the scale of the practice, which had been criticised by the judgment. Separately the Director agreed with the Council's Internal Audit Team that they would audit practice for the period after the judgment to report on whether practice was currently compliant with the law. The outcomes of these findings are not part of this audit report.

1.3 The specification devised by Haringey Children's services defined the scale and the scope of the audit as –

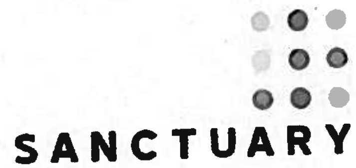
- To review an appropriate and representative sample amounting to 30% of section 47 enquiries in the First Response service, between May 2011 – March 2013.

- To review the process and procedure followed and whether they followed agreed social work practice and procedure;

- To review whether parental consent was sought to share information. If not the reason why and whether relevant records were kept of such decision;

- To review the decisions made, in particular, on threshold and reasonableness of such decision;

- To review whether there were full written records of the enquiries and the outcomes and whether they comply with best social work practice and procedure.



2.0 The Review Team

2.1 The review team consisted of 3 full time independent Social Care managers. These managers were selected on the basis of their experience in

- performance and service management
- conducting Peer Reviews
- completing Safeguarding audits for LSCBs
- achieving 10 years consistent service in Gateway services

2.2 The review team accessed support from one of the Lead Practitioners from Sanctuary Social Care to maintain the independence and focus of the audit role whilst enabling clear communication lines with the LBH Project Manager.

3.0 Liaison with LBH Employees

The nominated LBH project manager led on the development of the specification and project mobilisation. It was agreed that there would be weekly updates on the performance of the Review Team, the progress of the audits and feedback on the preliminary findings.

LBH and Sanctuary Lead Officers met on 4 key occasions

- 24th June 2013 –Project briefing and mobilisation discussions
- 1st July 2013 – Project start
- 15th July 2013 – Project exit planning
- 15th August 2013 –Project Review with DCS.

The purpose of these meetings constructively:-

- clarified the project goals and deliverables
- identified resource needs leading to weekend access to the building and additional ICS technical support
- Identified key issues and project dependencies – building in a mechanism to review the project plan and resolve potential bottlenecks and impact issues
- Reviewed overall performance and outcomes

4.0 Methodology

4.1 Skylakes appreciates that Children's Social Care has a strong history of practice evaluation and relied on best practice guidelines as governed by:-

- Section 11 of the Children Act 2004, accompanied by statutory guidance on making arrangements to safeguard and promote the welfare of children.

- LBH's own procedures as adopted from London Child Protection Procedures (4th Edition) Working Together to Safeguard Children Guidance, (2013, 2010 & 2006).

- The new inspection framework setting out standards for scrutinising practice, caseloads support for staff and the quality of management oversight.

- Data Protection Act 1998 & Commencement Orders

- Human Rights – Act 1998 and 2000

- Achieving Best Evidence (ABE) , Practice Guidance 2007

- Framework for the Assessment of Children in Need and their Families , 2000[1]

4.2 The quality assurance audit consisted of 400 randomly sampled S.47 investigations initiated during the period of May 2011 – March 2013 with an additional 24 records examined, narrowing the scope of the review on these 24 to:-

- determining the recorded evidence of whether parental consent was sought to share information
- the recording of the reasonableness of the application of threshold
- the recording of full written records of the enquiries and the outcomes and whether they comply with best social work practice and procedure

The associated file documentation was not considered on the understanding that all relevant information was held on Framework I, (FWi). The audit was desk-based and conducted via access to FWi. It did not include interviews with Council staff or service users and the only direct communications with the nominated practice/ ICS manager was limited to queries regarding familiarisation to FWi and email notifications clarifying safeguarding concerns.

4.3 Skylakes proposed the audit tool attached as Appendix 1. The audit tool criterion was modified from the C4EO approved audit tool. The PSW and Interim Head of Service for the First Response Team were consulted on the audit tool design on the 28th June 2013.

4.4 The audit commenced on the 1/7/2013 and concluded on the 19/7/13, allowing the equivalent of 7 working days for analysis and the drafting of this report.

5.0 Findings

5.1 This report is a quantitative analysis of 424 case file audits. The figure of 424 represents the total number of cases reviewed exceeding the contract target of 400.

5.1 (i) It is important to confirm that all of the audits are based on what can be evidenced from FWi. How far this reflected the fieldwork undertaken depended on the quality of the recordings. Whilst almost two thirds of the work reviewed had deficiencies identified in the recordings, more than two thirds met the reasonableness of decision standard in the application and use of the s.47 threshold.

5.1 (ii) Section 47, 1989 Children's Act and associated guidelines,(set out in s.4.1) dictates that a S.47 enquiry/investigation should be initiated in the following circumstances:-

a) Where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm in the form of physical, sexual, emotional abuse or from neglect

b) Following an Emergency Protection Order and /or Police Powers of Protection

c) Immediately when there is a disclosure, allegation or evidence that a child is suffering or likely to suffer significant harm.

d) Where there are childcare concerns combined with domestic violence, parental mental illness, parental substance misuse or alcohol misuse such as to cause agencies to reasonably assume the children are exposed to parenting that is not prioritizing their needs and that the inability to meet those needs will lead to impairments in the children's health and development .

e) Where there are concerns for a pre birth child suggesting s/he is likely to suffer significant harm.

The enquiry should involve an assessment of the child's needs and the ability of those caring for the child to meet those needs. The aim is to decide whether any action should be taken to safeguard the child. The child's parents/carers should beinterviewed, as well as the child (unless the child is too young). The assessment will also include information from the child's education establishment, health providers and any other relevant professionals involved with the family.[i]

5.1 (iii) Information sharing

Partnership with parents is one of the principles underpinning the Children Act 1989 and what this means in the context of data-sharing is set out in the statutory guidance 'Working Together, 2010' at paragraph 5.35 -

"The parents' permission, or the child's where appropriate, should be sought before discussing a referral about them with other agencies unless permission-seeking may itself place the child at increased risk of suffering significant harm."

The Data Protection Act requires that personal information is used fairly and lawfully. For information sharing to be lawful, it must comply with the relevant provisions of the Data Protection Act as well the broader legal framework. Child protection investigations are governed by the Children Act 1989 and statutory guidance such as Working Together to Safeguard Children (2010). For information sharing to be lawful, it must comply with the provisions of the Children Act and the associated guidance.

5.2 Summary analysis by stage.

5.2 (i) Referral & response

Most referrals were deemed to be appropriately made with sufficient information. The Screening team appears to generally have made appropriate decisions based on documented risk and progressed cases in a timely manner. In a significant number of cases acknowledgement letters could not be located. Whilst the issue of Acknowledgement letters where is it safe to do so, falls within the Department of Education's guide of 'best practice', this audit accepts that across many Local Authorities this requirement proved to be a labour intensive exercise for many Local Authorities and was later relaxed to reflect the need for local protocols to be developed in the context of available and reasonable resources.

A small number of audits found no evidence of cross reference to previous referrals with 4% of the sample representing issues that appeared to have been assessed or explored previously. In short, the screening and management oversight did not reflect that the current referral concern had already been assessed distinguishing that whilst the referral source was different the concern was the same and had already been assessed.

The courts have long recognised the importance of a chronology in social work decision making. In the 2000 High Court judgment, Re E and Others (Minors) (Care Proceedings: Social Work Practice) 2000 2 FLR 254 FD, Bracewell J issued guidelines to social workers which included the recommendation that the key document of every social work file should be a running chronology of significant events kept up to date so as to facilitate identification of serious and deep rooted problems rather than the circumstances triggering the instant referral.

This audit finds that the consistent use of a Social work chronology at the start and the close of Children's Social care involvement may well provide a remedy.

In general, complete and clear factual details were present on the referral forms. With the exception of religion – all other available details relating to the child and family demographics were present on the referral form. The detail regarding professional contacts was less consistent in the referrals sampled pre the introduction of the MASH system. Post MASH the auditors were assured that most cases had names and contact details recorded.

Initial Assessments

A common feature of the s.47 assessment/enquiry practice process involves generating a non effective initial assessment (IA) to activate the strategy discussion which then opens up the CP core episode. However, the audit found that the FWi prompt seeking parental consent was part of the IA process and the First Response Team may wish to consider ensuring that the consent aspect in the IA is included as a mandatory section in the agreed single assessment template, to narrow the potential for recording errors.

S.47 Enquiry /Core assessment

The statutory gateway privilege provided under s. 47 of the Children Act 1989 requires clear decision-making at the point of accepting the referral and agreeing threshold for s.47 the absence leads to vulnerability for challenge on the grounds of lawfulness. Working Together 2010 provides in sub sections 5.56 – 5.59:-

- decide whether section 47 enquiries should be initiated and therefore a core assessment be undertaken under section 47 of the Children Act 1989, or continued if it had already begun under section 17 of the Children Act 1989;

- plan how the section 47 enquiry should be undertaken (if one is to be initiated) including the need for medical treatment and who will carry out what actions, by when and for what purpose;

- agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. If the child is in hospital decisions should also be made about how to secure the safe discharge of the child;

- determine what information from the strategy discussion will be shared with the family unless such information sharing may place a child at increased risk of suffering significant harm or jeopardize police investigations into any alleged offence(s); and

- determine if legal action is required.

- agreeing a plan for how the core assessment under section 47 of the Children Act 1989 will be carried out – what further information is required about the child(ren) and family and how it should be obtained and recorded;

Further, Working Together, (s.5.35) notes that:-

"The parents' permission, or the child's where appropriate, should be sought before discussing a referral about them with other agencies, unless permission seeking may itself place the child at increased risk of suffering significant harm."

Skylakes suggests that the following should be treated as the threshold test: will seeking consent place the child at increased risk of suffering significant harm?

In this context the audit reports the following -:

a) Recorded management oversight setting out clear justifications for sharing information without consent at the start of the S.47 enquiry could only be evidenced in 32% of the cases reviewed. The audit found that the investigating Social worker later secured consent but not before checks had been undertaken.

b) 6 of the cases submitted for review fell outside of the audit timetable commencing in May and June 2013, post judgment. It is important to note that all 6 of those cases had clearer management oversight and specifically addressed the issue of consent and the process to be followed in undertaking the investigations in accordance with best practice guidelines.

c) Recorded management oversight of the conduct of the s.47 enquiry was noted on 42% of the cases reviewed. The audit found that the lack of consistent, detailed management recordings in this respect had a correlation with the low percentage of cases that had full recordings capturing the outcome of the S.47 enquiries. The cases where the management oversight was evident, directive and followed established procedures appeared to encourage more detail recordings of for example.

- the initial child interview
- observations from the referrer and or professionals involved
- ABE summary outcome and
- CP medicals

d) Best practice [2] suggests that the way in which interviews are conducted can play a significant part in minimising any distress caused to children, and increases the likelihood of maintaining constructive working relationships with families. The lack of detailed case records precluded the auditors from assessing the extent to which the quality of practice assisted with the eventual outcome.

Service User Contact/ Involvement of the Child

The majority of the cases sampled, (83%) contained reference to the child being seen, and where appropriate (in terms of age and understanding) having been seen alone. This is a strength and the theme was pronounced throughout the audit findings. Some of the assessments however did not reflect a clear sense of the child and appeared to focus more on the adult description of the events rather than a more objective finding based on observation and interview of child/ren. That said, the final outcome of the core assessments reflected the necessary degree of challenge regarding the parental position and did not appear to reflect a collusive standpoint. The social work recordings denoted an ethos/intent of protecting children and evidenced rapid response from the Child abuse investigating team (CAIT) and Social care. This was judged as evident in two thirds of the cases audited.

Adherence to Procedure/Timescales

The records contained little by way of detail about the process of the investigation - this may to be located elsewhere in the file but was not obvious to the audit process. There were examples of investigations being completed outside statutory timescales with insufficient clarity around why delay occurred and what interim safeguarding measures had been put in place. For example, s.47 investigations should be conducted within 15 working days, if the circumstances dictate then the findings and the needs can be subject to an updated strategy discussion to plan the next phase of any investigations. It is important to say that closer examination of the files allows some assumptions to be made regarding the reasons but this audit notes the need for this to be made explicit in the recordings, given the rapid response of the initial intervention. A stronger focus on management recording will assist in addressing this issue.

Feedback to Service User/Referrer

There was evidence, (73%) within the assessment and case notes of feedback to the parents or other relevant professionals involved.

The audit could not conclusively determine whether established procedures had been followed in relation to case closures at the end of a s.47 enquiry because of the lack of detailed recordings. The audit drew no concrete assumptions between the case closure rate without recorded management directions on the conduct of the investigations and the numbers from the sample that led to an outcome of 'not substantiated'. In short the sample reviewed where cases were closed did not appear to advance or meet the threshold for services at s.17. The audit sample did not evidence the development of Child in need plans or signposting for intervention at Tier 2. This may need closer examination to explore the cases where there was a determination of no further action for Children's Social Care and eliminating the need for step down intervention to a Tier 2 provider.

6. In relation to the specification

The audit was required to address the following specific points:-

To review an appropriate and representative sample amounting to 30% of S.47 enquiries in the First Response service between May 2011 – March 2013.

The original spreadsheet contained the details of 450 children. It should be noted that 6 of the cases fell outside the audit timeline as they commenced after the 31st March 2013 and a further 10 appeared not to have an actual s.47 episode. These are recorded as 'S.47 no longer required'.

Audits were completed on 424 cases randomly selected from the provided spreadsheet. Based on the information shared in the mobilisation meeting on the 24th June 2013 this represents the 30% sample of the S.47s initiated between May 2011 and March 2013.

To review the process and procedure followed and whether they followed agreed social work practice and procedure;

The audit noted that whilst some of the social work recordings were detailed there appeared to be limited reference to ABE procedures; risk assessment tools, London Child Protection Procedures and Working Together to Safeguard Children, 2010. The recordings were in the main child centred, attempted to address the referral concerns and the evidence for the cases jointly worked with CAIT demonstrated immediate safeguarding actions.

The audit could not comment on the application of the LADO process, as it is not uncommon for the detail records of LADO Professional Strategy Meetings to be recorded separately.

To review whether parental consent was sought to share information for 10% of the sample. If not the reason why and whether relevant records were kept of such decision;

The audit notes that this was a clear area of vulnerability. The audit could not conclude that the indicators of unlawful data gathering were clearly demonstrated, but the lack of recordings setting out the management oversight prior to completing checks is a cause for concern. In the 6 cases reviewed where s.47 were initiated post March 2013 there were clear signs of improvement. For example, appropriate clarifications held within the confidentiality of the 'fire wall' of the MASH; recordings setting out further risk to the child if

parental consent was sought; reference to Fraser competence and the right of the young person to determine when a parent should be notified and the parental and young persons views regarding compliance to medicals.

The vulnerability relates to the timing of when consent was sought and the sample set out evidence that consent was sought in the main after checks undertaken. Consent forms appeared to have been signed in retrospect. Notwithstanding the vulnerability the target of 10% was satisfied. .

To review the decisions made, in particular, on threshold and reasonableness of such decisions;

From the overall sample the auditors were satisfied that the case circumstances at the point of referral in the main established the concern for significant harm or likelihood of significant harm threshold and justified either a joint investigation or a S.47 single agency enquiry. The audit noted that only 23% of the cases reviewed lacked sufficient clarity to justify the threshold for immediacy and significant harm in the professional judgement of the auditors with 68% of the cases reviewed meeting the s.47 threshold with recorded proportionate decisions on the case file.

The question of reasonableness is more complex and for the 23% of the cases that lacked sufficient clarity the audit noted that it might have been more appropriate to provide support to the family under S.17 of the 1989 Children Act without using the more authoritative safeguarding approach employed under s.47.

To review whether there were full written records of the enquiries and the outcomes and whether they comply with best social work practice and procedure

This audit found that the lack of detailed written records was an area of vulnerability. The percentage of cases with limited or no full written records of the s.47 enquiry in the period May 2011- March 2013 was significant, (59%). Missing information included

- notes of interviews with the child and the parents
- reference to case history and previously initiated case chronologies
- supervision direction
- analysis of the information received following checks, for example a theme of 'health visitor no concerns' rather than details of when the child was last seen, observations of parenting afforded and general health care pre and post birth

In a high proportion of cases reviewed it was the view of the auditors that there was a strong safeguarding ethos in terms of the timeliness of the response to reported concerns and allegations with the index child being seen within 24 hours of the referral decision. There was also evidence of the needs of other children in the household being considered.

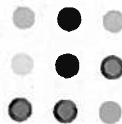
CAF assessments seen were generally of good quality and informed the enquiry and assessment process. The audit found that the use of a written agreement linked to utilising the influence and services of partner agencies was a useful social work safeguarding tool. Clarity and consideration needs to be given to ensure primary carer/s understand that signing the document may also infer consent to share personal and sensitive information.

Referrals meeting the threshold for a child protection enquiry were responded to promptly and information gathering and the co-ordination of a response with the police is recorded in a timely fashion albeit lacking the detail of the agreed plan on FWi. The auditors suggest that the plans to further develop FWi should assist duty managers to consistently record the application of threshold for initiating s.47 and ensure the issue of consent is addressed before checks are undertaken. The audit noted that only 23% of the cases reviewed lacked sufficient clarity to justify the threshold for immediacy and significant harm in the opinion of the auditors.

An analysis from this sample noted that the cases were closed with no step down plan. Details of these cases are being provided to the Director for further review in parallel and to inform the mechanisms already in place to increase the Child Protection risk and investigative training for managers and social workers. This should also consider ABE training as the audit evidence suggests that only in a minority of cases was reference made to preparation for initial or ABE interviews. For example the case notes largely reflect narrative on the events as opposed to reflection and analysis on why children retract reliability, memory and linguistic capabilities and how these impacts on disclosures. Further, the auditors note that the Director of Children's services plan to expand on 'what works for practice developments' opportunities will address and generate learning and reflection on pertinent practice issues governed by the Data Protection & Human Rights Acts.

HEAD OFFICE
Neptune Marina
27 Neptune Quay
Ipswich
Suffolk
IP4 1QJ

National Switchboard: 0800 046 1166
Fax: 0800 046 7285
Web: www.sanctuarysocialcare.com
Email: info@sanctuarysocialcare.com



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