States of Jersey - Children's Service

Independent audit of the quality of front line practice and management

Phase three - child protection plans

Context for the audit

The States of Jersey has invested in and embarked on an ambitious programme to improve the quality of children's social work in Jersey. This commenced with the implementation of rapid improvement plans and was augmented in April 2015 by the two year plan for sustained improvement, (SIP) the key outcome of which is to have good and outstanding social work services for children.

Change and progress in key areas of service delivery will be tested through independent audit and inspection. The Director of Children's Services (DCS) commissioned this independent audit to provide a baseline of front line practice and management. It took place between May and early July 2015.

Scope

The independent audit was conducted in four phases, each focusing on a key area(s) of service delivery within which it is essential that practice and management are robust.

Phase 1: the multi-agency safeguarding hub (MASH), covering responses to and decision-making in relation to contacts and referrals and child protection enquiries undertaken under article 42 whether these originated from the MASH or from social work teams. Phase one took place on 11 and 12 May 2015.

Phase 2: assessments and child in need planning. Phase two took place on 26 and 26 May 2015

Phase 3: child protection plans.

Phase 4: care plans for children looked after.

Key themes, underpinned audit activity in all four phases. The extent to which:-

- Work improves outcomes for children and young people.
- Practice is child centred, reflecting the focus to 'think child'.
- Dimensions of equality are effectively addressed.

Audit approach

A set of audit criteria were developed. These were derived from the Jersey Children Law (2002), the department's minimum standards document, 'Working Together' (2013) and Ofsted's inspection evaluation schedule (2014).

They cover compliance with statutory regulation as well as what is considered to be 'good' practice. The criteria were agreed in advance with the DCS and were discussed with staff during the audit.

My approach was that of a 'critical friend' i.e. evaluative and developmental. Case audits were undertaken alongside managers and these discussions offered the opportunity for reflection on practice and management. Positive practice alongside learning from cases was highlighted.

Six cases were randomly selected by the auditor, from the list of children on a child protection plan on 30 April 2015, and a list of children and young people de-registered in the last four months.

The sample included children at different stages in their journey through a child protection plan; children very recently registered, on a plan for 12 months and approaching two years on a plan. The sample reflected, where possible, a spread of gender, age and ethnicity and included, where known, children with disabilities.

Some of the children and young people had a lengthy history of contact with services. While this was taken into account as context, the focus of the audit was on risk assessment, decision-making and protection planning over the last twelve months within the children's services department. Thus I was not able to examine the quality of work undertaken by partner agencies in ensuring that children are protected.

The audit process was complicated by the difficulty in accessing key documents within paper and electronic records e.g.partner agency reports to ICPCs and review conferences and conference minutes.

The audit was further complicated by the fact that each child does not have their own electronic record. Reports and documents are stored on the L drive, but can relate to any sibling.

Cases referred back to senior managers

One case, [REDACTED] , was referred back to senior managers for review of the quality of risk assessment and change-focused purposeful work. Action was needed to secure a safe long term plan for the child. ([REDACTED])

Key findings:-

In the light of the detailed verbal feedback already provided, this is a summary of the review's key findings, some of which are reflective of the finding of phases one and two:-

- Taken as a whole, child protection practice and planning was below minimum standards for all the children and young people in this sample. Poor practice was systematically embedded in multi-agency child protection ‘cultures’, processes, planning and decision-making. Some of the basic building blocks of effective child protection practice and management oversight were not in place. Drift and lack of impact was not challenged.

- More recently, the context within the children’s service was one of change, including staff turnover, moves across teams and sickness. At the same time greater demands were placed on staff due to an increase in the number of applications made to the family proceedings court. Managers are very aware that oversight of children on protection plans was not at the standard that they wanted to achieve.

- Organisational changes, sickness and staff movement led to changes of social worker for several children and young people. This resulted in a ‘start again’ approach as new workers and managers struggled to become familiar with complex and longstanding issues.

- Delays in responding to enquiries that highlighted risks and potential risks was evident in the last six months of 2014.

- Practice was not systematically underpinned by clear risk assessment that assesses the nature, severity, frequency and duration of harms that children and young people have suffered or are likely to suffer. None of the children had received a core assessment, before or during their time on a plan.

- There was a lack of clarity re the threshold required to make a protection plan, particularly relating to registrations for emotional harm and neglect of children who have received services over some years. Three children and young people were registered when the recorded evidence did not show how they were likely to suffer significant harm.

- Four of the child protection conferences failed to clearly identify the nature, range and severity of harms that children were suffering. Facts and evidence were not consistently separated from multi-agency worries and concerns. Decision-making was confused. Differences in the levels of risk that siblings faced were not identified.

- In two instances practice up to the point of registration was effective in protecting children. These cases were characterised by clear precipitating incidents followed by sound child- focused initial assessments that clearly identified risks and harms. The reasons for registration, were clear, although not necessarily well summarised in the conference minutes. ([REDACTED])

- None of the six children and people had a comprehensive child protection plan that identified risks/harms, strengths and resilience, what needed to change or the support, actions and timescales needed to make children safe. One plan did have clearer and more specific actions that were clearly related to assessed risks.

- Post conference protection planning and intervention was not purposeful and focused and did not incorporate regular oversight of changing levels of risk. Engagement by partner agencies was variable. As a result, protection planning for five children and [REDACTED].

- There was very limited or no evidence of any management oversight and supervision of the cases of four of the six children and young people. At worst, no supervision sessions were recorded on one file since 8 April 2013.

- Practice and decision-making is not consistently child-focused and there is too little emphasis on the child's daily experience and the effects of parenting on their health, development and safety.

- Understanding of the impact of differences relating to diversity and equality is limited.

- Managers responded positively and non-defensively to the opportunity to explore cases in depth and consider wider questions in relation to thresholds and risk. They were able to develop individual case action plans in relation to those aspects of practice, management and recording that were below minimum standards.

Outcomes

- Risks were reducing and outcomes had improved for two children as a result of early protective action in one case, and the removal of the young person posing a risk in another. ([REDACTED]) [REDACTED]) Outcomes for two children were mixed; their health and development which were progressing well at registration remained positive, but the extent of risks or harm in their family remained unclear. ([REDACTED]) It was not possible to determine how far outcomes were improving for the remaining child, ([REDACTED]) due to the lack of information about the impact of the work being undertaken.

Child-centred practice

- Social workers did not consistently visit children on protection plans at the required frequency. Sometimes this was due to sickness. It was sometimes difficult to identify from the electronic record the occasions on which children have been seen. In one example, the social worker made regular visits to the home ([REDACTED]), whereas in another ([REDACTED]) statutory visits had been missed due to sickness. [REDACTED] and the manager was not able to confirm that visits had been made but not recorded. ([REDACTED])

- Practice is mixed in relation to conveying children or young people's views. Two initial assessments completed in the CIRT team ([REDACTED]) were sound examples of child focused work, enabling children to share their worries and fears about the parenting they received. Their views were well conveyed to the ICPC, either in person or through the social worker. This was good practice. Also positively, a young person's views about being on a plan was made clear ([REDACTED]), and they participated well in review conferences. In other cases social workers did not make positive relationships with children, so their views were unknown. One child commented negatively as their third social worker, in not many more months, arrived to meet them.

Equality and diversity

- As was found in the previous two Phases, needs arising from dimensions of equality were not taken into account e.g. where English was a second language, a view about whether parents needed the services of an interpreter was not taken. Protection plans did not fully address children's needs arising from disability. ([REDACTED])

Timeliness of action to protect children

- [REDACTED]. While some work took place, it was not purposeful or focused on identifying and examining the full range of risks to which the young person had been and was continuing to be subject to. ([REDACTED])

- Intervention between 2007 and 2013 failed to respond appropriately and effectively to a number of allegations of physical and emotional abuse made by three children. ([REDACTED])

Risk assessment

- Overall, the quality of risk assessment in this case sample was poor. Recording did not demonstrate a methodical and analytic approach. This was most striking in relation to children who could be experiencing neglect or emotional harm and where agencies had been involved over a period of time. Most notably:-

    1. Children and young people who had already experienced a number of interventions were brought to conference with a lack of clarity about parental capacity, associated risks and their impact on children.
    2. What was known about past harms was not consistently recorded or evaluated e.g. the significance of a sibling being subject to three previous protection plans, for the same issues of neglect.
    3. Facts were not separated from supposition or hypotheses; for example '*concerns* that X had coerced other females (i.e.teenagers) into sexual intercourse'.
    4. The harm that children or young people experienced was not described in necessary detail i.e. the context for the harm, its specific nature, its severity and frequency. Phrases such as 'ongoing domestics' were recorded as part of ICPC minutes.
    5. Inaccurate conclusions were drawn on the basis of facts e.g. that a child had experienced a 'relatively stable childhood', in the context of severe domestic abuse, and a number of other concerning behaviours.
    6. Insufficient attention was paid to evidencing protective factors and resilience, including from within the wider family network.

- Risk assessment within the two initial assessments that led directly to an ICPC was sound.

- A consistent theme was that deficiencies in information gathering and assessment at an early stage in a child's journey through services were not remedied at a later point. For example, a weak initial assessment, translated into a weak report for the ICPC which in turn failed to consider all risks and needs, and this was then followed by an inevitably limited protection plan. [REDACTED] The corollary to this, noted elsewhere, was the link between stronger and child-focused assessments and clearer decision-making as a foundation for protection planning.

- [redacted]The core assessment is the key opportunity to assess known risks and identify further risks. It is very concerning that, despite the fact that some children were escalated to an ICPC after a period of other work and/or were subject to protection plans, a core assessment had not been completed for any of the children in this sample. In some instances, it appeared that a core assessment had never been considered. In others, core assessments were significantly delayed, despite decisions at ICPC ([REDACTED]) and instructions from managers that they should be. ([REDACTED]) Other core assessments were not updated during the life of the protection plan. [REDACTED].

- None of the chronologies were up to date or comprehensive, as was found in Phases one and two of this audit programme.

Appropriateness of child protection registration

- Registration was appropriate for three of the six children and young people.

- In three cases registration was not appropriate as the threshold for 'likelihood of significant harm due to the care given by the parents' had not been clearly identified and/or there was evidence to the contrary.

[REDACTED]
[REDACTED]

- Conference participants did not appear to have a clear understanding of the legally mandated threshold for registration. The discussions recorded in the minutes showed that a robust appreciation of risks and their severity was very variable. Registration was seen, in some instances, as a vehicle 'to get support' or as a guarantee of social work involvement. Some agencies were concerned about de-registration in case a child in need plan was not put in place, and this appeared to be one factor in children remaining on a plan. Where previous multi-agency action had not resulted in professionals' anxieties decreasing, collective critical reflection on the nature and impact of work undertaken before moving to a further period of registration did not appear to have taken place.

The quality of child protection plans

- The quality of child protection plans was weak, and this would be a very significant finding in any inspection. None of the children had a protection plan that met minimum requirements.

- Until May 2015, accepted practice was for the ICPC to produce a short outline plan. All of the children and young people had such a plan. The outline plans contained the same three very broad aims for all children in the family, and were accompanied by a list of actions and tasks, which invariably did not cover all of the siblings. These actions were usually vague ([REDACTED]) and insufficiently specific. For example, an outline plan might suggest that a young person 'attends sessions', but not identify the outcome expected from this. Alternatively, that a child 'must attend school' without identifying who would contribute what to ensure that this could begin to happen. Plans were not clearly linked to the harms the child was suffering and the risks to which they were subjected.

- This limited outline plan was not developed into a recognisable protection plan for any of the children. A 'family' protection plan was produced within which the needs of and risks faced by individual children got lost.

([REDACTED]) Practice was to embed the list of action identified at the ICPC within the minutes of core groups and different social workers took different approaches.

- As a result, none of the plans identified:-
    1. Desired outcomes and what needs to happen to be satisfied that the plan can be discontinued.
    2. The child or young person's individual needs.
    3. The harms they had suffered or were likely to suffer.
    4. Who was at risk from what or from whom.
    5. Resilience and protective factors.
    6. Clear tasks and actions linked to risk, as well as timescales for achieving these.
    7. A contingency plan should change not be forthcoming.

- There was no evidence that chairs of child protection review conferences challenged the lack of plans that met basic standards.

- The impact of all of the above is that it was very difficult to evaluate to what extent, if any, the plan was successful and what had or had not changed. Further down the line this would present considerable challenges in preparing cases for court.

- A new child plan pro-forma has now been developed, but it is at a very early stage and was not implemented in any of the cases reviewed.

Multi-agency child protection planning

- An appropriate range of agencies were invited to ICPCs and review conferences. Attendance overall was variable. Not all members appeared to have a clear understanding of their role or contribution. Conferences were routinely attended by agencies who did not have a role in carrying out the protection plan e.g. housing agency.

- Reports from agencies were not consistently made available in advance of meetings. This meant a large amount of information had to be digested in a short time, and is likely to impact on the preparation undertaken by participants before making the serious decisions required in these meetings.

- Not all files contained copies of the reports prepared by agencies, and this is attributed to a lack of a clear process for ensuring that these are uploaded on to electronic records. I was told that social workers would be expected to bring paper copies from the conference and place them on the paper file and that sometimes reports are sent electronically, but that this too depends on individual social workers saving the report on the 'L drive'.

- The pro-forma for presenting information includes very detailed prompts, but I saw few reports that appeared to have followed these. Information e.g. [REDACTED], was missing. Agencies did not consistently evidence their views, or distinguish facts from concerns or hearsay. Reports from the police were generally factual and clear.

Initial and review child protection conferences

- I was informed that it is usual practice for a chair to meet the parent and, if attending, the child immediately before a conference, but this could not always be verified from the recording. It is not a required field on the conference report.

- Parents were generally present at conferences, and the records evidence their active participation. In some instances young people were also present and made a valuable contribution. ([REDACTED])

- Initial and review conferences did not fulfil their purpose. Conference records did not evidence that decision making is systematic or explicit.
    1. Evidence, including historical information, and known facts were not clearly established.
    2. Facts were not consistently separated from worries and concerns about the possibility of future harm.
    3. Information was left vague and its impact on the child was unexplored e.g. ‘ x (parent) has a personality disorder’.
    4. Contradictory information was not examined e.g. from one participant that a child was thriving and developing well, and from others that there were clear harms from the quality of parenting.
    5. The nature and extent of the different harms to which children had been subject or might experience were not clearly outlined.
    6. Risks were left unclear.
    7. The impact of parenting on children’s behaviour, health and development was not made apparent.
    8. There appeared to be no collective understanding of the need to identify harm and why it was significant, and to differentiate this from parenting that, while not in any way ideal, did not lead to significant impairment of health or development.
    9. Differentiation between the needs of and risks to which different children in the family were subjected was often unclear.
    10. Decisions were made, and the opinion of those taking part was recorded, but the evidence underpinning the decisions was not clear.
    11. Some recording was inappropriate and unhelpful e.g. ‘[REDACTED].

- Conferences did not systematically consider each child in turn, their needs, risks and harm and protective factors. Instead each professional made a contribution which could range across several issues and children. This resulted in often 15 or more pages of reported text that showed discussions that were unstructured, left information re potential risks unclear and sometimes contained unhelpful value judgments about parents.

- The recording of conference minutes is a significant concern. There is a high level of informality e.g. participants are referred to only by their first name.

- A lack of independence and challenge on the part of chairs was a feature of these cases. No chair challenged the lack of a developed protection plan or the lack of purposeful and effective work to implement the plan. Some positive practice was recently seen ([REDACTED]) where a chair overruled the majority view that a protection plan could be discontinued due to the lack of clarity about the extent to which known risks had reduced.

- I could find no clear administrative process for the timely distribution of conference minutes. I was informed that these are sent (sometimes delayed) to the social worker who is then responsible for uploading them on to the electronic record. When the records are not on the file it is difficult to determine why this has occurred.

- I was not able to explore the type and extent of training that participants across agencies have received in relation to risk identification, assessment and decision-making about significant harm. It appears that, if this has taken place, it has not had a positive impact.

Work undertaken to implement child protection plans

- The sample was characterised by a lack of robust, purposeful and focused work to reduce risks.

- Planning for several children was impeded by social worker sickness and changes of worker. This led to a lack of focused work, missed visits and contacts, duty workers 'filling in' and a tendency to 'start again'. This fact was recognised in some core group and conference minutes. Social worker sickness and its impact in carrying out the plan was cited as one factor in decisions to delay de-registration.

- Children and young people on the child protection register were not seen at the required frequency. For example[REDACTED].The manager could not verify that another child ([REDACTED]) had been seen on any occasion following an [REDACTED] order made in [REDACTED]. Thus, social workers were not able to build trusting relationships with children or explain to them why they were subject to a protection plan.

- There is limited evidence of ongoing direct work with children that is linked to the disclosures that they have made or the range of needs that have been identified. There are a few examples of moving towards a more positive approach, such as three children offered some direct support from the intensive support team ([REDACTED]), although this appeared to cease without a clear explanation as to why. [REDACTED]. However, a lack of comprehensive assessment meant that other potential risks e.g. arising from domestic abuse did not appear to be tackled.

- The quality of oversight of child protection plans by core groups is a significant concern. Core groups were not consistently held for all children at monthly intervals. It is positive that in one case this was picked up by the chair at a review conference. Multi-agency attendance varied from strong to very limited. Core groups did not review progress against the plan, nor consider evidence that risks are changing.

- Examples were seen of decisions, made without a clear rationale, to change key elements of a protection plan without this being discussed at a review conference. For example, [REDACTED]

Step up and step down from child protection plans

- [REDACTED]) were stepped up from a child in need plan. Despite extensive prior involvement the nature and severity of risks was not clearly understood. [REDACTED].

Management oversight and supervision

- The management oversight of child protection plans was weak, as were the systems and structures surrounding child protection planning.

- Arrangements are in place for team managers to sign off child protection plans, and examples were seen of managers raising concerns re non-completion, although this had not had the desired impact. However, more generally managers, conference chairs and others appear to have accepted a position where child protection planning takes place without being underpinned by clear risk assessment and a realistic plan.

- In four of the cases there was no evidence of supervision taking place in relation to children on protection plans. ([REDACTED]) record demonstrated that some level of critical reflection did take place, but this was not evidenced in the recording. The impact of these serious omissions was the lack of challenge to drift, delay, purposeless planning and non completion of assessments. More positively, there was evidence of supervision, at the assessment stage, for the two of the three children whose journey to a plan proceeded via MASH and CIRT.

Recommendations

The sustained improvement programme is overseeing a number of actions. These recommendations are intended to underpin or supplement these and target the most important priorities for change:-

To ensure that thresholds for child protection registration are consistently applied:-

1. Review the guidance that is disseminated to staff in relation to the decisions to be made and the process for reaching them, to ensure that staff across agencies clearly understand what is required.

2. Ensure that staff across partner agencies clearly understand the threshold for instigating a child protection plan and that they receive support and training to carry out their decision-making responsibilities.

3. Ensure that there is a clear process for protecting young people who are at risk of harm from other young people and that the needs of both are fully considered.

To ensure that multi-agency child protection conferences are effective:-

1. Review the current approach for sharing information and making decisions about the risk and harm that children have suffered to ensure that:-
   - all children in a family are considered individually and this is recorded.
   - facts are separated from opinions.
   - there is clarity about the risks and harms that children have suffered or are likely to suffer and their impact.
   - decisions about registration are underpinned by clear reasons that are in line with legal requirements.

2. Minutes of conferences clearly record the information that is shared in relation to risks and harms suffered by individual children, including where information is unclear and that the reasons why children are likely to suffer significant harm are recorded.

3. Outline child protection plans clearly reference the known and likely harms that children are experiencing.

To ensure that child protection planning is robust:-

1. A child plan, to the new format, is urgently completed for all children and young people on the child protection register. The plan is agreed by all members of the core group, is signed off by the manager for the key worker and a copy sent to the ISS.

2. A multi-agency chronology is urgently completed for each child on a protection plan.

3. A core assessment is completed or updated for all children subject to a child protection plan.

4. All children on a protection plan receive visits from their key social worker in accordance with agreed frequencies. That these visits have the clear purpose of undertaking work to reduce the harms that children are experiencing. If sickness or other factors prevent these visits taking place, this is reported to senior managers so that appropriate action can be taken.

5. All children on a protection plan are seen alone, unless it is agreed with a managers that, given the particular circumstances, that this is inappropriate.

6. Core groups meet regularly. They explicitly review and record the progress that is being made against the plan and whether risks and harms are reducing.

7. Where children are not considered to be safe, the right level of action is taken according to the urgency of the situation.

8. Provide mentoring and development for staff across all agencies so that they understand the features of a ‘good’ child protection plan.

9. All staff participating in core groups are aware of the specialist range of resources and services available to children who have been or are at risk of significant harm.

To provide effective management oversight of children subject to child protection plans

1. All key workers for children on protection plans immediately receive regular child-focused supervision that is recorded. Supervision must critically reflect on progress to assess risks and harm, support the effective implementation of plans for children and prevent drift.

2. Ensure that all chairs of protection conferences receive regular supervision that provides critical reflection about the quality of chairing, decision-making, independence and challenge in the role.

3. Managers across agencies consider the current arrangements to provide consultation and support to staff in implementing child protection plans, especially the circumstances in which multi-agency professional consultation would provide appropriate support and direction.

4. Consider, when staffing and resource levels permit, a system of short focused 'placements' for managers directed towards identifying aspects of best practice in planning for children.

To ensure that managers and senior managers across all agencies have an accurate understanding of the quality of front-line practice:-

1. The Jersey Safeguarding Partnership Board:
   To develop a systematic multi-agency process to audit the quality of information sharing and decision-making within child protection conferences.

2. The Independent Safeguarding Service:
   To develop an audit process in relation to the quality of chairing of child protection conferences that includes routine dip sampling and periodic observation of conferences.

3. The Children's Services Directorate:
   To further develop and embed the routine dip sampling and auditing of the work undertaken to ensure that child protection planning is robust and purposeful.

The following recommendations from Phases one and two are also relevant to the findings of Phase three of the independent audit:-

To ensure that key staff across all agencies have a shared understanding of outcome - based work:-
To improve the lives of children and young people, ensure that staff across all agencies understand the basic features of outcome - based practice and that they consistently consider, review and record the impact of their work on improving outcomes for children.

To ensure that children are at the centre of practice and management:-

Develop a programme of learning and development that enables front-line staff to develop skills in direct work and risk assessment and to consistently use those skills.

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