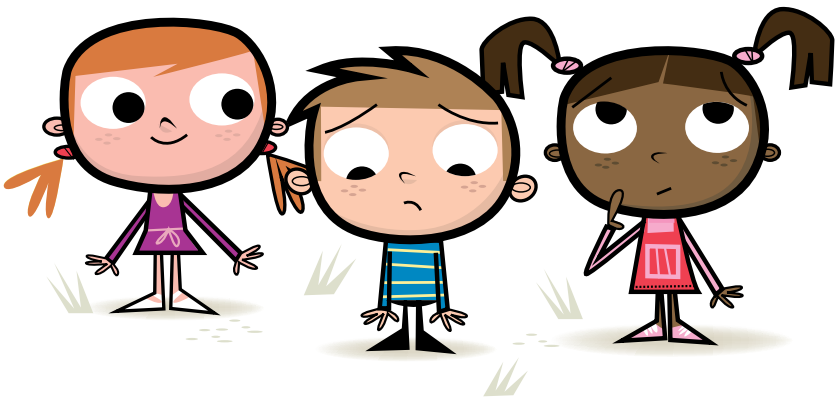
Annual Safeguarding Report 2010-11

Report of the Child Protection Board



Introduction

The Child Protection Board is responsible, on behalf of the Cafcass Board, for scrutinising the systems across Cafcass which contribute to the protection of children whose cases are referred to us. It also reviews how these systems interact and the action taken by the Chief Executive and management team when external policy or legislation changes, or when an incident which causes harm to a child is reviewed internally, or as part of a Local Safeguarding Children Board (LSCB) process. As this work could easily encompass all that Cafcass does, the Board has focussed on specific themes to guide its work. For the last year this has included: the arrangements for the induction and supervision of staff, as critical to practice standards; the process for undertaking checks on applicants and respondents in private law cases and what evidence there is from them of significant concerns; the findings from Serious Case Reviews (SCRs) and the work of the Learning Action Panel (LAP).

It is not appropriate for the Child Protection Board to give a formal assurance about Cafcass' performance in protecting children. The death or serious injury of any child is a matter of very great regret and distress, including to those practitioners who knew the child or family. It is not possible to say that even if the very best practice had been followed every child would have remained unharmed. What it is possible to say is that the processes and procedures are up-to-date, suitably presented and accessible. The structure for induction, recruitment and supervision are also appropriate. The ways in which Cafcass identifies concerns, sets up management reviews and takes the outcomes through the LAP are sound. However this needs to be put into practice, which is the responsibility of all practitioners, their supervisors and the management team. Considering the remit of Cafcass, where there are already concerns for children in public law and where families are under stress in public or private law, the number of serious incidents where Cafcass has some case knowledge to contribute is relatively small.

The Board membership in 2010 has included Mary MacLeod and Terry Connor, supported by Darren Shaw, Bruce Clark, Eileen Shearer and Mary Berwick-Sayers. Apart from regular meetings, members have visited five offices and sampled Cafcass Internal Management Review (IMR) reports. The support from the small National Safeguarding Team has been consistent and unstinting, and is appreciated.

Jennifer Bernard, Chair
Cafcass Child Protection Board

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1. Staff Training and Performance

The performance of frontline staff and their managers is central to the quality of the impact of Cafcass' services on outcomes for children and their families, including assessment and management of risk in the context of child protection. The Child Protection Board has worked through the practitioner and student development 'pathway', which runs from induction to the eventual achievement of 'assured competence'.

Induction

Each Cafcass practitioner and frontline manager completes the induction process set out in the Cafcass Induction Framework. This focuses on their individual support needs, professional support and development needs and information about performance and accountability. An Induction Checklist and a Personal Checklist are used to keep track of the induction activity.

Post-recruitment assessment of training needs

The specific training needs of staff are identified in the induction process, and development opportunities are planned to meet them, including designated support and mentoring.

Each practitioner and frontline manager has a written plan and identified service objectives for the first 12 weeks in post, annual service objectives and a personal development plan in place to feed into the annual appraisal process.

In addition, each Family Court Adviser (FCA) undergoes a 'confirmation in post' process after 12 months, through the appraisal process as part of the Quality for Children (Q4C) performance management framework. The latter sets out the performance required under each service objective, one of which is Safeguarding.

New frontline staff are required to attend mandatory core training modules on key designated topics: Safeguarding, Law, Domestic Violence, Direct Work with Children, and Risk Assessment. These are completed in their first year, leading to confirmation in post by the Head of Service.

Throughout their time in Cafcass, there is a requirement that all operational staff receive supervision every six weeks. At each supervision meeting, performance is assessed against a set of service objectives set out in the Q4C framework; for any aspect of performance considered "inadequate", an action plan is agreed and reviewed in each session.

Through this process, each practitioner's learning and development needs are identified and set out in a written plan which is then monitored in supervision.

Where a staff member does not meet a service objective such as Safeguarding, a range of development options is available, from individual coaching, close oversight and discussion of cases in additional supervision sessions, to attendance at core training events as a 'refresher'.

The annual appraisal process assesses performance overall and again each practitioner and manager has a personal development plan which is then monitored in supervision. An e-learning system now supports monitoring of training take-up across Cafcass.

Social work students / Newly Qualified Social Workers (NQSWs)

Each social work student completes a pre-placement questionnaire to identify their individual learning needs based on defined National Occupational Standards. Each also presents a learning profile setting out their learning needs at their initial meeting with their Practice Educator (PE), (an experienced FCA), who supports their development throughout the placement. The learning needs are met through regular supervision of a limited, carefully chosen caseload and formal training delivered in individual sessions and group learning. Cafcass practice requirements are also addressed through training sessions and reading of policies and procedures. Learning is assessed by the PE and the Cafcass Practice Learning Co-ordinator.

In 2010-11, 12 NQSWs were recruited to Cafcass. Their learning needs are nationally defined in a series of 'outcome statements' intended to increase knowledge and skills in core areas of practice. These are assessed at the beginning of the year, based on information from the course and the recruitment process and are monitored through a Continuing Professional Development plan, based on learning needs identified by the social work course and the Cafcass recruitment process. This plan is reviewed at the initial, midway and final meetings. NQSWs receive 'on the job' support from a mentor, with training delivered in individual and group activities. Additional training is identified

through the appraisal process and by the observations of the mentors or Practice Learning Co-ordinators. There is a post-NQSW questionnaire to establish what they have learnt and what they are still required to learn.

Cafcass is contributing to the work of the Social Work Reform Board and will feed into its processes and procedures any requirements and advice from the Board and its working groups as they emerge. Key messages from the Munro Review are also being monitored for this purpose.

2. Safeguarding screening in private law

2.1 Police checks

In the past year Cafcass' performance in receiving key information to support the assessment of risk of harm to children in private proceedings has improved significantly. Between April 2010 and March 2011 police checks were commissioned in almost 44,000 cases. At least two checks per case are undertaken, so the total is more than 87,000 Police checks for the period in question.

Requests for Police checks have been sent by Cafcass for 99.8% of service users in private law cases received in the year to date. The average time for Cafcass to request police checks has reduced from 12.7 working days in April 2010 to 5.1 working days in March 2011. The year to date average is 7.6 working days.

The average time for the police to return checks to Cafcass has reduced from 13.6 working days in April 2010 to 4.1 working days in March 2011. The year to date average is 10.2 working days.

The improvements in the processing of Police checks are the result of on-going discussions with the Association of Chief Police Officers nationally, with local police forces, and the establishment of the Cafcass Intake Team based at Coventry, and its adoption of a consistent national process.

2.2 Study for the Family Justice Review

To support the work of the Family Justice Review, Cafcass recently undertook a study of the harm and risk information included by applicants on 100 randomly selected C100 forms and of the additional safeguarding information revealed through Cafcass' police and local authority checks and FCAs' telephone interviews with parties.

In 25 of these cases the harm box was checked by the applicant. Among the 75 applications where there was no evidence of harm in the C100, 32% of applicants and 16% of respondents were found to have convictions or cautions relevant to safeguarding. These included offences such as: act of cruelty to a child / young person aged under 16 years, assault, battery, causing death by reckless driving, violent disorder, drunk whilst in charge of a child, and weapon and firearm convictions. The family was known to the local authority in 45% of cases.

Domestic violence was alleged in telephone interviews in 34 of the 100 cases. Of the 75 cases where the harm box was not checked by the applicant, domestic violence was alleged in 23 (31%) of these cases. This finding aligns very closely with Aris and Harrison's (2007) finding that, "In 29% of cases where applicants answered no to the harm question, examination of the court case file revealed evidence of a high level of violence."

Another important finding of the study was that among the 22 cases where there was no trace of the parties in either police or local authority checks, domestic violence was identified through FCAs' phone interviews in seven (32%) of these cases. This information could not have been discovered through any means other than direct contact with the parties.

Telephone interviews conducted by FCAs as part of their safeguarding checks also revealed hitherto unknown allegations of child sexual abuse, threats to kill a partner, and threats to abduct the child/ren.

These research findings confirm the vital importance of undertaking timely screening of private law cases, and of the work of Cafcass in safeguarding children in private law applications through assessment of the significance of all the information about the parties available and not just that voluntarily disclosed.

3. Cafcass' contribution to Local Safeguarding Children Boards.

There are just under 150 LSCBs in England. As of September 2010 Cafcass membership was at Head of Service level (or Operational Director in one case) on 23 LSCBs (15%) and otherwise at Service Manager level. Some of our managers are members of up to five LSCBs.

A review of LSCB membership was undertaken by the National Safeguarding Team in 2010 in view of difficulties in resourcing consistent and meaningful participation in LSCB processes. The review involved consultation with LSCB Chairs and Cafcass LSCB members. An options paper for a future approach was then considered by Cafcass' Corporate Management Team, with a strategy agreed for 2011-12. The review noted that Cafcass is, for the most part, represented at membership of the full board, with some inputs to sub-groups.

Working Together proposes that members are '...people with a strategic role ...able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account' (3.63). There has been a query regarding whether the Service Manager level is the most suitable to fulfil this remit.

Representation on specific LSCBs at senior level will now be decided by Operational Directors with Heads of Service, applying the following criteria:

a. Strategic importance e.g. pan-London; large unitary authorities and / or shire counties.
b. Local 'drivers' e.g. high numbers of public law applications; complex inter-agency relationships.
c. LSCBs / LAs in special measures.

Where it is decided that a Service Manager will act as LSCB representative, this will involve a minimum of one attendance a year to present national and local information and issues arising from Cafcass' work.

The Cafcass strategy for 2011-12 now requires a proportionate contribution as a named board partner under s13 (3) of the Children Act 2004, with funding to all LSCBs continuing at the current level of £550 p.a.

The National Safeguarding Team will make the following standard resources available to LSCB representatives on a dedicated intranet page by September 2011:

- LSCB membership role description and training to support this (e.g. through a MySkills e-learning module).
- LSCB 'member's pack' to include information on the statutory basis of Cafcass' membership and on establishing direct relationships between LSCBs and the newly established Family Justice Local Performance Groups.
- A standard s11 audit template containing national data with a prescribed local dataset for insertion by the local LSCB representative from contemporaneous management information.
- PowerPoint presentations on relevant changes to service delivery (e.g. Work to First Hearing and after First Hearing in private law cases, public law, proportionate working); matters on which we have substantial knowledge e.g. domestic violence; fatal assaults within the context of conflicted separation; statistics on the numbers of public and private law cases, trends, delays, actions taken etc.
- Data on complex safeguarding issues which may be proving hard to resolve e.g. information-sharing on domestic violence matters within Multi-Agency Risk Assessment Conferences (MARACs).

4. Serious Case Reviews – key lessons and actions

In 2010-11 Cafcass worked with 146,999 children.

Very sadly, a small proportion of children in those cases dies or suffers serious injury or other abuse. Often, such tragedies cannot be foreseen or prevented but whenever a Serious Case Review is commissioned, Cafcass contributes to this to establish whether there are lessons to be learned and whether our practice met the required standards, and whether or not the incident or death was preventable.

The key themes of IMRs undertaken into private law cases are as follows:

- Policy was not consistently followed by staff in respect of:
  - Recording
  - Inputting of data (by business support)
  - Safeguarding checks were not fully complete or within required timescales (see section on Police Checks above)
  - Inadequate assessment of the risk of significant harm contained in information in safeguarding checks leading to missed referrals to Children's Services
  - Courts not informed of incomplete safeguarding checks and the need for an adjournment.
- A lack of probing inquiry into information relating to domestic violence to identify the risks.
- Frequent changes of line managers and / or unclear case accountability meant that on occasions practitioners did not seek or receive appropriate support and direction.
- A lack of supervision of cases.

Most of these are basic errors rather than higher level issues of professional judgement, indicating the real importance of ensuring compliance with policy from practitioner and business support staff.

However at the time of the incidents in question in these cases neither the Cafcass Intake Team, nor Early Intervention Teams' services established precisely to counter such problems, was in operation.

As always, we find lessons to be learned and embedded from the rigorous scrutiny of private law work that IMRs provide. The Safeguarding Team was able to report both the learning points and robust organisation-wide actions taken, including the importance of filing reports to the court on time, and Cafcass' improvement in this area, and also by the improvement[1] in case allocation[2].

The key themes of IMRs undertaken into public law cases show more positive practice in some respects. There is some resonance with private law cases in the failure to adhere to some basic policies and procedures, notably in respect of recording and the referring of child protection concerns to Children's Services.

The public law IMRs focus primarily, however, on issues of judgment and the assessment of risk of significant harm. Cafcass practice has included positive elements, but the areas of concern identified include:

- Judgments being inappropriately influenced by individual practitioners' negative views of the looked after children system.
- Failure to identify the risk of and / or an under-estimation of the harm caused by child sexual abuse.
- A failure to re-assess and plan in response to new information or incidents suggesting increased risk to the child.
- Insufficient challenge of practitioners by their supervisors.

All the IMRs have shown extensive evidence of lessons already implemented, and over the past year it has been possible to reduce the number of recommendations to improve safeguarding practice, as stipulated in Working Together (2010).

The Chair and members of the Cafcass Child Protection Board consider IMRs and SCR reports to ensure that there is further scrutiny and that any identified issues or patterns that require additional action are fed back at operational management or Board level.

[1] The timeliness of filing reports to the courts improved in 2010-11 with 98.9% of section 7 reports filed on time with the courts in March 2011; a further 0.8% filed one to five days late thereby allowing the court hearing to go ahead as planned without delay (Source: Cafcass Annual Report 2010-11 page 33).

[2] The number of unallocated private law cases fell by 91.7% in 2010-11, from 2,180 in March 2010 to 182 in March 2011.

5. Applied learning in Cafcass

Cafcass ensures that learning points arising from all sources are considered by senior managers and the required changes to safeguarding practice are identified, implemented and monitored.

Currently, the Head of Service for Safeguarding & Practice Development coordinates a Learning Action Panel (LAP) chaired by the Chief Executive and attended by members of the Corporate Management Team and the Heads of Service for Quality Improvement. Its aim is "to enable organisational learning from a range of sources to be applied to improving future practice and systems" (Terms of Reference). It meets every two months to review key learning points arising from critical incidents, audits, inspections, complaints, and Serious Case Reviews. Actions are agreed for each and progress is monitored through an action log.

LAP review is required for all learning points where policy or procedure may require change, strategic planning may be affected or corporate risks are affected.

Examples of actions include dissemination of SCR findings through Channel C or the intranet, implementation of audit of key practice areas (e.g. Early Intervention Service) or commissioning a review of procedures (e.g. Safeguarding Framework).

6. Ofsted Inspections

There have been eight Ofsted inspections of Cafcass service areas in 2010-11. From October 2010, Ofsted was asked by the Government to focus its inspection efforts on monitoring improvements achieved through the Transformation Programme and the difference it is making on the ground in improving the timeliness of service provision. The inspections also became 'unannounced' to lessen the inspection burden.

The results of inspections this year have generally been encouraging. Inspectors noted the improving quality of our work with inspections in N1 (North and South of Tyne) and C1 (Derbyshire and Nottinghamshire) rating our services as 'good' – our most positive results ever. Progress in a third service area, C7 (Cheshire and Merseyside) was also rated 'good' with some outstanding elements in its post-inspection monitoring visit. Post-inspection monitoring visits in S3 (Greater London), C4 (Staffordshire, Shropshire, Herefordshire and Worcestershire), N3 (Lancashire and Cumbria) all found 'satisfactory' progress.

However, in S4 (Kent) weaknesses in the quality of our private law casework led to an 'inadequate' rating, although Ofsted did acknowledge the dramatic reduction in delays and backlogs in all work. A post-inspection monitoring visit of N4 (North Yorkshire and Humberside – now incorporated into N2 and N6) also found 'inadequate' progress. Both areas are now subject to intensive remedial programmes to deliver rapid improvement.

These action plans have been regularly monitored by the Operational Directors through Service Improvement Meetings and by the Chief Executive and Corporate Management Team (CMT) through the Service Area Assurance Board.

7. National Safeguarding Team contribution to the mitigation of organisational risks

The Safeguarding Team supports the mitigation of the elements of risk, set out below, identified in the Corporate Risk Register under the category of safeguarding (Risk 1), which is:

Risk: Failure to safeguard the children and vulnerable adults in the cases that we deal with.

Risk 1. Capacity gap linked to increase in demand causes failures in risk assessments and safeguarding checks.

The Safeguarding Team has contributed to screening and assessing the standard of initial risk assessments in line with Cafcass' Safeguarding Framework, and the consistent implementation of the Private Law Programme and the President's Guidance by:

- providing expert policy advice and case consultation
- reviewing and updating clear streamlined policies and procedures and audit tools
- developing of Risk Assessment Public Law and Early Intervention Services core training modules.

Risk 2. Poor performance management fails to highlight gaps in safeguarding practice.

- The Supervision Policy has been redrafted and will come into force as part of the implementation of the Operating Manual. The Quality for Children (Q4C) performance management framework for practitioners and operational managers is being revised with fewer descriptors and a simplified grading system, to improve the identification and management of poor performance.
- Performance issues identified through the SCR process are assessed for local and national prevalence and fed into the LAP where appropriate for management action to be considered.
- A structured process for monitoring the progress of SCR action plans has been implemented by the Safeguarding Team from early 2011. This reminds the local Head of Service to review and update the action plan so that the Safeguarding Team can issue updated plans to LSCBs as required. It also prompts exception reports on incomplete local actions to be provided to the LAP for the attention of operational managers.

Risk 3. Failure to implement mechanisms for effective monitoring and reviewing of 'safe minimum / proportionate working models' and appropriate prioritisation of duty / allocation cases, resulting in harm to children.

The Safeguarding Team contributes to the mitigation of this risk through:

- The development of core training modules in relation to Early Intervention Services and public law.
- Any information about delays in allocation obtained through the SCR process is passed to the organisation through the LAP for further consideration.

Risk 4. The standards of safeguarding practice in Cafcass are rated as inadequate by Ofsted.

The Safeguarding Team contributes to meeting safeguarding practice standards by delivering:

- A specialist consultation service for complex diversity cases.
- A safeguarding policy and case consultation service to frontline staff.
- Review and update of relevant policies in the context of the outcomes from Ofsted inspections and changes in national legislation or policies. The Safeguarding Framework review is in progress.
- Development of national training curricula for the core modules for frontline staff – according to the priorities of the Corporate Management Team.
- Co-ordination of Cafcass' contribution to SCRs and disseminating the learning from them.