Cheshire East Local
Safeguarding Children Board

LSCB Child Sexual Abuse Partnership Audit

February 2018

Contents

Executive Summary

This audit was undertaken to assess the quality of our support to children and young people where the concern is child Sexual Abuse in order to improve outcomes and practice in this area.

Five cases were audited which covered a range of ages and levels of need. Each agency audited their own agency's involvement based on evidence in their case records against a common audit tool. They all made a judgement on the quality of partnership working. Agencies then discussed their findings and the audit process in a multi-agency meeting.

The audit findings are summarised below in terms of our strengths and areas for improvement.

What are we worried about?	What's going well?	What do we need to do?
• Strategy meetings not involving all relevant partners and minutes not being routinely shared. • Length of time to source work with parents • Lack of focus of religion and culture from front door • Health records repeated difficulties in making contact with social workers, cancelled core groups. This needs a basic exchange of contact details at the outset. • Updates are required on the progress of criminal investigations to core groups to inform case progress. • There needs to be a greater awareness by partners of the work carried out with sex offenders to enable a greater awareness of the progress of the case. • No support for the non-abusive parent • The full implementation of the Signs of Safety into supervision of	• Evidence of multi-agency working – attendance at ICPC, information sharing, • All cases seem to have evidence of appropriate challenge when in the Child Protection arena • Practitioners at core groups	• Strategy meetings developments to be fully implemented. • Ensure that risk assessments are being routinely used. • Consider the application of the working/ written agreements including monitoring how they are used in practice. • Core groups should set as an action a request for police information when there is an ongoing criminal enquiry. • Pre-birth assessment policy – review the policy, what stage to refer, interventions. • Consider what information partners require to inform them of the implications of work with sexual offenders to the safeguarding of children.

practitioners. • Community safety and families when ongoing investigation, information changes and evolves so requirements will change		

Context

Joint Targeted Area Inspections (JTAIs) are a new type of inspection which was introduced in April 2016. These are partnership inspections, which will assess our effectiveness as a local area in identifying and meeting the needs of children and young people under a specific theme.

The Local Safeguarding Children Board (LSCB) agreed that a multi-agency audit should be undertaken to assess the quality of our services against the JTAI framework in order to inform and drive improvements to our services to improve outcomes for our children and young people.

The JTAI framework includes the requirement for the partnership to audit between 5-7 cases selected by the inspectors during an inspection. The framework states:

The local partnership should evaluate the children's experiences using its own mechanisms while taking account of the scope of the inspection. The evaluations should assess the overall strengths of the practice and identify areas for development.

If the partnership chooses, they may provide a summary of themes and any learning from across their evaluations.

This audit was used to trial a potential methodology for partnership audits should we have one of these inspections. Learning points from this have been identified and are included in the report.

Audit Methodology

The audit tool was developed from the tool used within LSCB multi-agency audits, and adapted to be specific to Child Sexual Abuse cases. The tool is included within appendix 1.

Five cases were selected from cases open to Children's Social Care where there was Child Sexual Abuse as a concern and was open in the last 6 months.

Partner agencies were asked to check their records to see whether the child/ young person or parents were known to them, and if so to complete the audit tool detailing the quality of their work in relation to the impact on the child/ young person. The Safeguarding Children in Education (SCIES) team undertook liaison with schools to assist with completing the tool. Auditors were asked to consider the last six months of their agency's involvement.

A multi-agency meeting was held to discuss the findings from the audit and agree strengths and key areas for improvement. Feedback on the audit process was also sought during this meeting and is detailed below.

Learning for JTAI Multi-Agency Audits

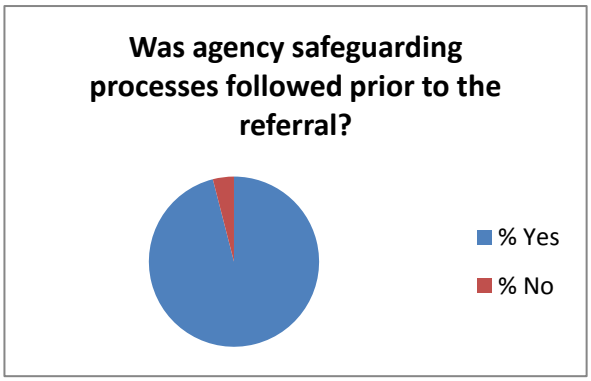
There were a number of points highlighted for learning from this process:

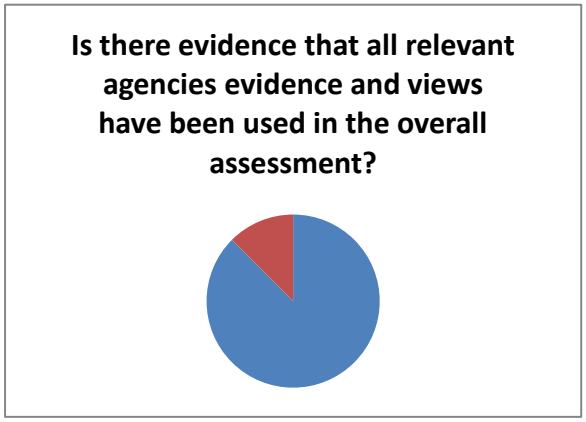
What are we worried about?	What's going well?	What do we need to do?
• Police and Domestic violence could only attend later in the day by which time the cases had all been considered.	• Representation from a mix of agencies, Childrens Social Care, SCIES, National Probation Service and Wirral 0-19. • The previous audit days and this one have taken less time than anticipated.	• Schedule the audit session for half a day to reflect learning.

Findings from the Audits

The Agency Audits identified that for the majority of case agency safeguarding processes where followed prior to referral.

Also 90% of audits found that the referral appropriate and was it made in a timely manner.





The audits found that in 88% of cases all recent agencies evidence and views had been used to inform the overall assessment.

Also that in 70% of the audits the appropriate assessment/screening tool was used. In 95% of cases the assessment was completed in a timely way and the family were supported while this was taking place.

71% of audits found that there had been a thorough risk assessment of the non-abusing parents to protect the children.

In 67% of cases there evidence that the needs of the child/ young person due to their ethnic origin, religion and culture were considered.

The impact of the risks for all family members and the community were considered and recorded in 96%.

93% of the audits judged that the plan was SMART and plan address identified risks and needs from the assessment.

All the plans developed and delivered involved and engaged the families in doing so.

92% of the audits judged that multi-agency work was effective.

However only 77% found that there were appropriate presentation at all relevant agencies at the strategy meeting and all other key multi-agency meetings.

Case notes were up to date in all cases and there was evidence of manager oversight, and of it providing case direction 93% of the time.

Where the case was stepped down there was always evidence of risk reduction and there was no agency disagreement on step down or closure.

Criminal proceedings were audited as having had no impact on case management in 61% and in 78% of cases it was judged that harmful sexual behaviour was identified at the earliest possible stage, and were appropriate interventions put in place.

Recommendations

Finding	Action	Lead	Date for completion	Outcome
LSCB – all agencies				
That practitioners have sufficient knowledge of work with sex offenders to understand the implications for Child Protection Planning.	Develop an information pack and strategy for its dissemination.	Learning and Improvement	Sub-group to set timescale	Evidence in LSCB audits of Tools being used. Information available on LSCB website.
Police information on criminal investigations updates the core group so that it can inform the plan.	Core group to routinely request a police update on criminal proceedings.			Evidence in LSCB audits.
Strategy meetings routinely involve all relevant agencies.	The current work to ensure that Strategy meetings are quorate is fully implemented			Evidence in LSCB audits.

A One Minute Guide is created to share the findings	Develop a One Minute Guide	Learning and Improvement	Sub-group to set timescale	Evidence in LSCB audits.
Pre-birth assessment policy	Review the policy in particular at what stage to refer and interventions.	Policy and Procedure	Sub-group to set timescale	Evidence in LSCB audits. Policy update on the LSCB Website.

Appendix A – Pen Pictures of the Children and Summaries

Case A

Unborn baby. There was a Child Protection Plan for the unborn baby's siblings.

What are we worried about?	What's going well?	What do we need to do?
• The Childs ethnic cultural needs were not considered. • Focus on risk but no mention of culture. • Practitioners had not been able to locate a Pre-birth assessment on LSCB website. • Services are not clear when an unborn should be referred, which can result in a delay in that happening. • Neither probation nor health at the strategy meeting. There is no record of health being invited. • The plan used a SMART plan model but didn't have any timescales for actions	• Referred promptly by CSC Service Manager. • Good use of additional assessments i.e. Lucy Faithfull. • Worked well with parents • Initial conference took place in the correct time and both parents were involved in the plan. • Management oversight • The Social Workers work was identified by the IRO for a good practice alert. • IRO identified older sibling's needs. • Midwifery demonstrating good working. • The intervention focused on risks and what worked well. It made sure mother protective parent and there was involvement with dad. • Positive multi-agency working with Probation involved. • Plan clear on what needed to happen and what the non-parents need to do as protective adult.	• Ensure that all SMART plans have a timescale. • Review Pre-birth assessment policy including timescale. • The current work to ensure that Strategy meetings are quorate is fully implemented.

Case B

9 year old female who's Step Dad had been accessing indecent images online. Also a younger and an older brother. Concerns about mother's capacity to protect.

What are we worried about?	What's going well?	What do we need to do?
• It was not clear what work has been completed with mum and how what had been done was evidenced. • Minutes from core group not circulated to all agencies involved. • Lack of knowledge in some agencies re risk assessments and interventions for Sexual Offences. Without this practitioners don't know how to consider the implications for Risk and Interventions. • The terms of the adult agencies differs from the child agencies so may not be understood and therefore appropriately factored in to assessments and interventions. • The information supplied to meetings by the Police representative did not cover the latest developments in the criminal investigation. • Health not invited to strategy meeting • Mum found out images severity at the initial conference and was considering a complaint. She should have had the opportunity to read the report prior to conference, unusually that didn't happen • Difficult as it was a police ongoing investigation. • Religion recorded as	• School observed a good relationship between the Social Worker and the parents. Also that the IRO chaired the CP conference really well and enabled the dad to contribute positively. • CHECS actions positive and referred to CIN/CP in timely manner • Assessment completed and working agreement put in place. • Safety plan from the onset put in place • The Social Worker spoke to all children separately in age appropriate way re risks posed by dad. • Timely decision to go to conference, positive, done quickly. • There was planning in case there was media involvement. • Health received minutes from the strategy meeting which was positive and very beneficial.	• Use of the "Withheld" option for religion on Liquid Logic to be reviewed to check if it is being used correctly. • Ensure that all reports for Child Protection Conferences are shared with parents prior to the meeting. • Ensure that Police updates for core groups include the latest information on relevant criminal investigations. • Consider what practice advice should be given where a criminal investigations results in an NFA or not guilty as there still may be a residual risk in the family. • The current work to ensure that Strategy meetings are quorate is fully implemented. This should also include the sharing of minutes routinely. • Consider what practice guidance should be given to children's safeguarding professionals where there is an adult sex offender.

Withheld on Liquid Logic. This may be due to the option chosen by the "loader" rather than it actually being withheld.		

Case C

A Police Referral where there are allegations that the step father committed a second rape, the previous one was on a family member.

What are we worried about?	What's going well?	What do we need to do?
• Cancelled CIN meetings on file • Couldn't find evidence of children's views and day to day lives • No evidence of active work taking place to increase mums capacity to protect • No information of extended family support and views to manage risk • Referenced a written agreement, but Cheshire East is moving away from written agreements • Police updates to the core group would have been beneficial. • No evidence of completed tools apart from LADO one. • Evidence of a lack of understanding of other's professional language and acronyms • No evidence risk to community considered, he was also perp of violence not just sexual abuse. • Strategy meeting involved only police and Social Care even though case open on CiN plan	• Referral came from the police and was sent to CiN/CP within 24 hrs. Appropriate information provided by the police. Information from Health • Information provided appropriate level regarding risk • Child Protection plan had SMART actions with timescales • Health Visitor challenged the mum when she attended a hospital appointment with the perpetrator. The Health visitor also informed the correct people • Case supervision • A Strategy meeting took place when 2nd allegation took place • The case was referred to LADO as the perpetrator worked with children. Good attendance and appropriate recommendations.	• The current work to ensure that Strategy meetings are quorate is fully implemented. This should also include the sharing of minutes routinely. • Ensure that Police updates for core groups include the latest information on relevant criminal investigations. • Improve practitioner knowledge re risk assessments and interventions for Sexual Offences. • Work to be done with non-abusing parents • Where the risks lay, implications of wider community considered • Where a letter of expectations is used it should be for a limited time until the Child Protection plan is put into place as the Letter of expectations is not a legally enforceable document..

for number of months		

Case D

Boy aged 6. Older half-brother is the risk.

What are we worried about?	What's going well?	What do we need to do?
• Mothers capacity to change is not positive, repeated pattern • School are concerned that mum's additional needs have not been taken into account and how they affect her capacity to protect. It may be that she has been given tasks but does not have the capacity to achieve them. • Learning disability assessment for mum identified August 2017. Refereed for this but when care proceedings started this was discontinued. • Neglect a feature in this case. The use of the GCP would have been advantageous. • Supervision of the case concentrated on process and needed to be more reflective using a Signs of Safety Approach • Supervision didn't take into consideration what life was like for children, appears an oversight • Mum didn't believe son was a risk • Health attended for the Strategy meeting and discovered it had taken place the day before. • There was a loss of focus on neglect, graded care profile not in the plan. • Not having a good	• No drift or delay in the last six months. • Responded too immediately by police and EDT • Child biological father at the conference and gave his views • Strategy attended by head teacher is DSL • Clear actions on Child /protection Plan. • Assessment completed after S47 investigation, police and CSC explained purpose of investigation clearly on visits. • School felt Social worker and Family Support Workers engaged well with parents. • Letter of expectations used rather than written agreement and was monitored though Child Protection Plan. • Supervision done in line with policy and management oversight. • File up to date and evidence of multi-agency working. • Evidence in contact records of attachment of the children to their parents. Children's wishes and feelings noted. • At a Child Protection Conference a professional challenged core group attendance.	• SoS – agencies are at different points to adapt • The lived experience of the child must be taken into account. • Where a parents capacity to protect is questioned need to ensure this is assessed. • Where the possibility of neglect is identified the completion of the GCP should be tasked within the plan. • The transition into adult social care should be improved. • The current work to ensure that Strategy meetings are quorate is fully implemented. This should also include the sharing of minutes routinely.

interface for child to adult social care transition into adult social care had an impact on the older siblings.		

Case E

The child was 2 years old. The case was referred by the police as the father had indecently exposed himself to girls in the community.

What are we worried about?	What's going well?	What do we need to do?
• Strategy meeting held 3 days after referral attended by Police and Social Care and then a meeting; Health invited but could not attend. • Practitioners having access to appropriate material to inform them about the implications of different religions and cultures on the capacity of parents to protect. In this case how to "stand by your" partner but still protect yourself and your children. • Managing communications with church's where their influence with the parents will have a bearing upon the capacity of the parents to protect. • The amount of time it took for the perpetrator to access an appropriate programme.	• During the parenting assessment the religion and ethnic were explored • Grandparent's actively involved. • Professionals wanted evidence of change before stepdown/close. • Minutes of meeting evidenced reports from probation briefing on the perpetrators progress on his programme. • There was delay in identifying support for mum; this was challenged by the IRO. • Plan was smart and addressed what needed to happen to reduce risks. • Psychological assessment covered the implications of the religious beliefs and culture. • Statutory visits focused on children.	• The current work to ensure that Strategy meetings are quorate is fully implemented. • Services for mum • Explore if the intervention for the abusing parent can be accessed at an earlier point. • Ensure that practitioners have access to appropriate material to inform them about the implications of different religions and cultures on the capacity of parents to protect, including the influence of religious organisation.

Appendix B: Audit Guidance and Tool

Multi-agency Audit on Child Protection Case Conferences

Guidance Notes:

- The audit should review **how the work considered the child**. This also applies to those services whose core work is with adults.

- Please do not include identifiable data in the report – **please use initials instead of names** for the child/ young person and family members. Please make it clear what the relationships between people are – for example please use 'dad', 'step brother', 'Health Visitor' instead of PK. **Please give the unique ID at the beginning of the form for the child/ young person – this is given on the case list.**

- You should complete a **separate audit form for each child** in the audit and this should be from **your agency perspective** and from the details held in your agency's records.

- You should look back at the **last 6 months of your agency involvement.** For example, if you have had no involvement for the last 3 months, please consider the involvement starting 9 months ago.

- **Please give detail against each point**. We will have a multi-agency meeting following the audit to agree a judgement on the quality of our work as a partnership for each case, so we need to understand what informed your judgement on your agency's work. **Please include what could have been done better.**

- **If you have answered 'not applicable' please explain why.**

- The audit asks you to make an **overall judgement** about the quality of the work of your agency for each section – please use the Ofsted grading's below:

    - **Outstanding** – practice that is significantly above the standards for their own and multi-agency working
    - **Good** – practice that consistently meets the standards for their own and multi-agency working
    - **Requires improvement** – practice that is inconsistent in meeting the standards for their own and multi-agency working
    - **Inadequate** – practice that fails to meet the standards for their own and multi-agency working

We would like to recognise and celebrate good practice, and there is a space for this to be identified at the end of the form, this includes any work from your own or another agency.

Thank you for taking part in this audit. Please return the completed **anonymised** forms to LSCBeast@cheshireeast.gov.uk. Please note this email address is not secure to external agencies, if you need to send us any confidential information please contact us at LSCB@cheshireeast.gcsx.gov.uk

Case no (UIN)	
Agency completing the audit:	
Audit completed by (name and title):	

Quality Assurance Information

No.	Question	Response (Yes/No)	Comments on Quality of Work
Q1	Was agency safeguarding processes followed prior to the referral?		
Q2	Was the referral appropriate and was it made in a timely manner?		
Q3	Is there evidence that all relevant agencies evidence and views have been used in the overall assessment (including specialist services, e.g. adult services where appropriate)?		
Q4	Was the appropriate risk assessment/screening tool used? e.g. GCP, CSE screening tool, Brook Traffic Light Tool or the Simon Hackett Continuum etc.		
Q5	Was the assessment (CAF, C&F, and AIM) completed in a timely way, and was the family supported while the assessment was taking place?		
Q6	Is there evidence that the needs of the child/ young person due to their ethnic origin, religion and culture were considered?		

Q7	Was the impact of the risks for all family members and community considered and recorded? • Child/ young person and siblings • Parent(s) • Partner		
Q8	Is the plan SMART and does the plan address identified risks and needs from the assessment?		
Q9	Was the family involved and engaged in developing and delivering the plan? • Child • Parent(s) • Carers Are their views evidenced?		
Q10	Was the quality of multi-agency working effective? If no, was this challenged by your agency or another agency?		
Q11	Was there appropriate representation from all relevant agencies at the strategy meeting and all other key multi-agency meetings?		
Q12	Were agency actions completed in the timescale identified at the multi-agency meeting? If not was there any challenge to the delay? If so by whom?		
Q13	Were the case notes up to date and clear about the work that had been undertaken, the relation to the plan and the impact on the family?		

Q14	Is there evidence of manager oversight, and does the manager oversight offer case direction?		
Q15	If the case was stepped down or closed is there evidence of risk reduction?		
Q16	When the decision was made to step down/ close the case did your agency agree with this? If yes, what was your agency's rationale for why risk was reduced? If No, did you agency challenge that recommendation and provide a rationale?		

Judgement on the overall Quality Assurance Information

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Questions specific to areas of sexual abuse:

Only answer the ones that are relevant to the case being audited

No.	Question	Response (Yes/No)	Comments on Quality of Work
Interfamilial adult perpetrator			

Q17	Is there a thorough risk assessment of the non-abusing parents to protect the children?		
Q18	Have criminal proceedings had a significant impact of the management of the case?		
Child Sexual Exploitation			
Q19	Does the plan incorporate disruption techniques in order to protect the child?		
Harmful sexual behaviour			
Q20	Was the harmful sexual behaviour identified at the earliest possible stage, and were appropriate interventions put in place?		

Judgement on the Quality of the Work specific to sexual abuse:

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Judgement on the Quality of the Work Overall for your Agency:

Judgement	Comment on why this judgement was made

Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Any areas of good practice identified (this could be in your own or another agency):

Any areas of improvement identified (this could be in your own or another agency):

Any issues identified (this could be in your own or another agency):

Please provide a short statement summarising your agencies finding from this audit:
