Rapid review of child protection arrangements

Interim findings

June 2023

This report is also available in Welsh.

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Estyn
Arolygiaeth Ei Fawrhydi dros Addysg a Hyfforddiant yng Nghymru
His Majesty's Inspectorate for Education and Training in Wales

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Introduction

In response to a number of tragic child deaths across England and Wales, the Welsh Government asked Care Inspectorate Wales (CIW) to lead on a multi-agency rapid review of decision-making in relation to child protection.

The purpose of this review is to determine to what extent the current structures and processes in Wales ensure that children's names are appropriately placed on, and removed from, the Child Protection Register when sufficient evidence indicates that it is safe to do so.

A multi-agency team with representation from Healthcare Inspectorate Wales (HIW) and Estyn was established in December 2022 to ensure a consistent and rigorous approach to this important piece of work. His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) also contributed to aspects of this review.

Collectively, we are committed to raising standards and delivering positive outcomes for the most vulnerable children and young people in Wales. With this in mind, we have worked closely with, and collected information from, a range of partners including the seven health boards, education and social service providers, alongside third sector organisations. We would like to take this opportunity to thank everyone for their invaluable contributions to this important piece of work.

We should be mindful of the ongoing and significant challenges being faced by the workforce in relation to the recruitment and retention of practitioners, particularly in children's social care. The demand for services and complexity of needs continue to impact on child protection practice.

These are the interim findings from our rapid review and we will publish a more detailed analysis in September 2023.

Our approach

This review focuses on the requirements of the Wales Safeguarding Procedures, in line with the Social Services and Wellbeing (Wales) Act 2014, statutory safeguarding guidance Working Together to Safeguard People and Keeping Learners Safe (Guidance for local authorities and governing bodies on arrangements for safeguarding children).

We have adopted a collaborative approach to this review, whilst ensuring that the voices of children and young people who are / have been on the child protection register are heard. To date, in partnership with HIW and Estyn, we have:

- Undertaken targeted activity in seven local authorities and four health boards.
- Distributed national surveys to all local authority children's services and education departments, health boards and police forces across Wales.
- Sought the views of children, young people and their parents / carers, and practitioners through the distribution of a SHOUT survey, in partnership with 'Mind Of My Own'.
- Facilitated a series of engagement workshops in schools and with a range of education managers and practitioners.
- Started to undertake a desktop review and thematic analysis of the minutes taken at child protection conferences and core group minutes across Wales.
- Engaged with a range of children's advocacy groups and organisations.

This consultation work is ongoing.

We have also incorporated the findings captured in other pieces of work such as our Review of Care Planning for Children and Young People Subject to the Public Law Outline Pre-proceedings, and our Joint Inspections of Child Protection Arrangements (JICPA).

This has been a collaborative effort, providing us with valuable information and data. This will enable us to identify good practice and areas for improvement.

We plan to hold a series of stakeholder learning events during Summer 2023 prior to the publication of the full review in September.

Summary of interim findings

1. The understanding and implementation of thresholds as to whether a child is experiencing, or is at risk of experiencing, significant harm, are mostly good, although it's not consistently understood between partner agencies and local authorities in Wales.

2. Current processes, in line with the Wales Safeguarding Procedures, are enabling effective information sharing. However, in practice, this varies across Wales.

3. Multi-agency arrangements work well in many areas of practice, although some areas could be further strengthened.

4. Practice varies in relation to how well children's lived experience is taken into account when making decisions about safety. A child's right to participate also needs to be strengthened in some of the processes held in line with the Wales Safeguarding Procedures.

5. There is collaborative working across strategic partners but this does not always lead to consistent oversight of frontline practice.

6. Overall, the decision-making process about registration and deregistration is appropriately followed. However, practice around assessing and maintaining focus on risk of significant harm varies.

7. Practitioners' focus on the risk of significant harm to a child is inconsistent. Independent Reviewing Officers (IRO) have an important role in ensuring that the focus remains on the risk of significant harm to children. They also hold a critical expert role in explaining thresholds.

Interim findings

Thresholds and information sharing

We looked at whether children receive the right help and protection because of the application of appropriate thresholds and effective information-sharing (PART 1).

Application of appropriate thresholds

The understanding and implementation of thresholds as to whether a child is experiencing, or is at risk of experiencing, significant harm are mostly good, although it's not consistently understood between partner agencies and local authorities in Wales.

+ Managers in children's services applied thresholds appropriately, with timely progression to the right service for children and families, including a rationale for intervention. This was particularly evident in regard to the threshold to proceed to undertake section 47 enquiries and proceed to initial child protection conferences.

− The threshold for significant harm is not clearly understood for some partner agencies such as schools. Where referrals are not accepted, partners are often unclear as to the reason.

Conference invitations from children's services in Swansea and Blaenau Gwent include a clear outline of the reason for the conference and the conclusion of the Section 47 enquiries. Health colleagues find this useful in ensuring that professionals, parents and the wider family understand the concerns and risks prior to the conference.

Interim findings

Thresholds and information sharing

We looked at whether children receive the right help and protection because of the application of appropriate thresholds and effective information-sharing (PART 2).

Information sharing

Current processes, in line with the Wales Safeguarding Procedures, are enabling effective information sharing. However, in practice, this varies across Wales.

+ Overall, there is good information sharing between agencies, resulting in appropriate referrals being made to children's services.

+ Appropriate information is being shared by partner agencies as part of section 47 enquiries and for Initial Child Protection Conferences and Review Child Protection Conferences.

− Threshold documents are not always available to support partnership working. When they are available, not all partner agencies are aware or utilise them.

− On occasions, the information shared about the risk of significant harm and the analysis of the impact of this risk on the child is not explicit enough to ensure that the right level of support is put in place.

Monmouthshire education department can securely access live social services information about a child whose name is on the Child Protection Register, enabling them to provide the right timely support.

Interim findings

Multi-agency arrangements

We looked at whether children are protected through effective multi-agency arrangements.

Multi-agency arrangements work well in many areas of practice, although some areas could be further strengthened.

+ Initial Child Protection Conferences are well attended by partner agencies. This provides an opportunity for all agencies to share information about a child and their family from their perspective and informs decision-making.

+ Schools are often a safe place for children, and school staff are able to share their knowledge of the child well in these conferences.

− Across Wales the police do not routinely attend Review Child Protection Conferences. Whilst this may be appropriate on occasions, there will be times when their safeguarding role and expertise are required. Consistent health representation would also be beneficial where relevant.

− Initial strategy discussions / meetings are mostly routinely held with police and children's services only. The urgency of some situations means that this is an appropriate approach to take. There would be significant benefits to include all relevant professionals at these important safeguarding meetings, notably school representatives, given their level of knowledge and contact with individual children.

Interim findings

Children's individual needs

We looked at whether professionals ensure that children's lived experiences and individual needs (including linguistic needs and rights to advocacy) are understood and included in decision-making about safety.

Practice varies in relation to how well children's lived experience is taken into account when making decisions about safety. A child's right to participate also needs to be strengthened in some of the processes held in line with the Wales Safeguarding Procedures.

Children are seen and seen alone when there are concerns about their safety. This provides them with the vital opportunity to share their views and for practitioners to understand what daily life is like for them.

Children's voices, wishes and feelings are appropriately shared by social care practitioners, health visitors and representatives from third sector agencies. The individual voice of a child however was often missed when they were part of a large sibling group.

Information shared by children could be better captured, with improved emphasis on what they may be worried about and what is important to them.

Children's participation at conference and in core groups needs to improve as we saw limited evidence of children and young people participating in meetings. Whilst acknowledging that it isn't always appropriate for them to attend, subject to age and their stage of development, children and young people's participation needs to be further promoted.

Although children's' and families' culture and linguistic needs are acknowledged, care must be taken to ensure that important documentation is produced in their language of choice.

Merthyr Tydfil County Borough Council has recently consulted with relevant stakeholders on how children, young people and their parent's / carers' voices can be maximised at the point of conference. A separate agenda item is now included to ensure that children's and young people's voices are shared in a manner they are comfortable with.

Interim findings

Leaders and managers

We looked at whether leaders and managers understand the experiences of those children and families who need help and protection.

There is collaborative working across strategic partners, but this does not always lead to consistent oversight of frontline practice.

+ Statutory services are committed to working together to fulfil their legal duties to safeguard and support children on the child protection register and their families. This approach helps to ensure that children and families benefit from relevant expertise.

+ Collaborative working across local authority education services is effective. Local authority education services work well with their schools to ensure that children whose names are on a Child Protection Register receive the support they need.

+ Health board staff working with children and families where there are concerns about children's safety are well supported by managers and health board safeguarding teams.

− Quality assurance practices, which support leaders and managers in having an oversight of the numbers of children whose names are on a Child Protection Register in their area and any related themes, vary across Wales.

Interim findings

Decision-making

We looked at whether decision-making about registration or deregistration is clear and evidence based.

Overall, the decision-making process about registration and deregistration is appropriately followed. However, practice around assessing and maintaining focus on risk of significant harm varies.

- In most cases, names were appropriately added to and removed from a child protection register.
- Practitioners clearly focus on the risk of significant harm to children and assess this accordingly. However, we saw some examples whereby agency reports for conferences were not sufficiently focused on the risk of significant harm.
- Children would benefit if there were clearer references to contingency plans if improvements made were not sustained.
- On some occasions we saw evidence of professional 'over optimism', insufficient reference to the progress made, and risk of significant harm in the future.
- At times, more focus is required on the safety plan once a decision is made to hold an Initial Child Protection Conference. This is important to address immediate safety issues.
- On occasion, care and support protection plans were overly focused on being adult and task led, with insufficient focus on what needs to change to promote the child's safety.

Interim findings

Establishing whether or not a child is at risk

We looked at whether practitioners establish if a child is at risk and / or has experienced significant harm and remain focused on assessing whether there are changes, whilst supporting a child and their family.

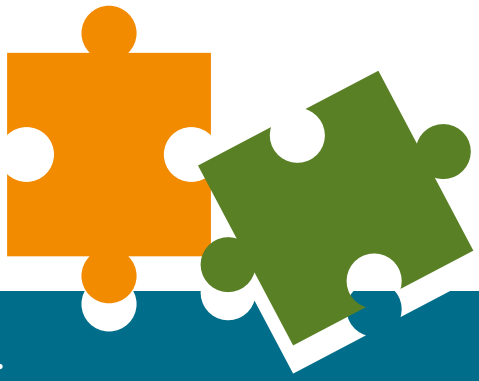
Practitioners' focus on the risk of significant harm to a child is inconsistent. Therefore Independent Reviewing Officers (IRO) have an important role in ensuring that the focus remains on the risk of significant harm to children. They also hold a critical expert role in explaining thresholds.

Children and their families benefit from consistent chair person attendance providing continuity of decision-making at conference.

Family Network meetings, also known as Family Group Conferences, are utilised appropriately to develop support networks for children and their families, as well as serving as useful forums for the identification and management of significant harm.

Information is shared in relevant reports and this is helpful to inform the assessment process, but, overall, we saw gaps in the provision of clear, consolidated assessments.

During the observation of a Child Protection Conference in Gwynedd, we saw the chairperson meeting and greeting the family members at the start of the conference, immediately placing them at ease. The chairperson was consistent and had chaired the previous meetings. They appropriately ensured that discussions centred on progress and changes made.



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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Digital ISBN 978-1-83504-167-3