Annual Safeguarding Report: April 2014 to March 2015

1 The quality committee: remit and membership

The purpose of this paper is to provide to the Cafcass Board a succinct overview of the safeguarding activities of Cafcass, and of the work of the Quality Committee in the period April 2014 to March 2015.

The Quality Committee's remit is to scrutinise, and to provide assurance to the Board in respect of, the quality of casework and the steps taken by the organisation to mitigate risk to the delivery of a safe and high-quality service to children, families and the Courts. Its membership during 14/15 was as follows:

- Mary MacLeod (Chair)
- Fay Selvan
- Ian Butler (to September 2014)
- Honor Rhodes
- June Thoburn - Special Adviser to the Committee

2 The work of the Quality Committee

The Quality Committee met four times in 2014/15, receiving reports and scrutinising the following:

- A rolling quarterly report into the **notifications of deaths and serious incidents** involving children and adults who are, or were, in receipt of Cafcass services.
- A quarterly summary of **Cafcass submissions to serious case reviews**, which generally take the form of Individual Management Reviews (IMRs).
- Progress on **quality improvement**, including scrutiny of the action plan that arose from the **Ofsted inspection**.
- **Inspection of Cafcass offices** by the FJYPB.
- A **national quality audit** summary report (which built on similar audits that took place in 13/14).
- Analysis of the **Learning and Development Programme**
- Evaluation of **pilots** (Cafcass Plus; Pre-proceedings).
- The Cafcass **research programme**, including reports into completed pieces of research.
- Review of the **strategic risk register**.
- The second annual Cafcass **Quality Account**, and the second annual **survey of users' views**.
- **Area Quality Review** guidance.
- Improved **audit tools and the proposed** Outcomes Framework**.**

3 Serious Case Reviews (SCRs)

Child Deaths and Serious Incidents

Table 1 below provides data relating to the number of child deaths and serious incidents that were notified to the National Child Care Policy Manager in 2014/15, alongside comparative

data for the previous three years. The Quality Committee receives quarterly reports setting out: the numbers and profile (e.g. by age, gender and type of case) of child deaths and serious incidents; and summaries of Individual Management Reviews (IMRs) which commonly form Cafcass' written submissions to SCRs. These reports enable the Quality Committee to scrutinise the information, seek further information, and assure itself that lessons are being learned and appropriate action is being taken to address shortfalls in practice.

Table 1: number of child deaths and serious incidents

Category	2011/12	2012/13	2013/14	2014/15
Number of children that died	22	24	32	24
Child deaths public law/private law	12 / 10	16 / 8	23 / 9	15 / 9
Serious incidents (excluding child deaths)	36	39	66	77
SCRs to which Cafcass contributed	15	11	30	26

In respect of table 1:

- Fourteen of the deaths were of children currently known to us, and ten were of children previously known to us. We were notified of a further eight children who had died but had never been known to Cafcass. Typically, in these cases we had known a parent and/or half-sibling.
- Of the 24 deaths, 11 are thought to be as a consequence of maltreatment. There were a further two where it is unclear whether maltreatment was implicated in the death, and four suicides. This is a total of 17 deaths[1] where maltreatment is, or may be, a feature. The other seven deaths were 'natural causes'.
- The number of notified child deaths has dropped from last year though, as the number of deaths is so small when set against the number of children we work with per annum, no significance should be attached to fluctuations in numbers.
- More telling is the continuing high number of SCR submissions made by Cafcass. This is discussed in more detail below.
- 77 serious incidents were notified in 14/15, a slight rise on 13/14 when there were 66 such notifications. The rise is probably accounted for by staff having been asked to make formal notifications of child sexual exploitation cases. More recently it has become possible for the data to be captured by the Electronic Case Management System (ECMS), and formal notification is no longer required. The number of serious incidents reported has doubled since 2011/12, we believe this is also a result of changes in the level of reporting rather than a significant change in the numbers of children significantly

[1] Suicides are included in this figure as they form one of the criteria for an SCR being convened, and as there is commonly a history of significant harm in those reviews to which Cafcass contributes.

harmed. It is important to note that we cannot extrapolate from this data to form a general view of levels of child maltreatment across England.

Submissions to SCRs

Cafcass contributed to 26 SCRs in 14/15, slightly fewer than in the previous year but considerably more than the two previous years. Until 13/14 we typically contributed, on average, to about one SCR per month.

In last year's annual report it was possible to attribute the rise in our submissions to a concomitant rise in the convening of SCRs across England. The *First Annual Report of the National Panel of Independent Experts on Serious Case Reviews* reported that 189 SCRs were convened between June 13 and June 14 – approximately twice as many as had been reported by a bi-ennial review (Brandon et al; 2012).

The national panel has not to date published its second report. However, it would be surprising if the number of SCRs has dropped as the panel commented, in its first report, on the *'deep reluctance in some instances to conduct SCRs'.* Following this the definition of serious harm was amended in *Working Together* to include: a potentially life-threatening injury; serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

Since March 13, when the decision as to how SCRs are conducted was delegated to LSCBs rather than stipulated at a national level through *Working Together* (the effect being to grant LSCBs greater flexibility), we have seen many different methodologies used. Our classification of the different types of SCRs to which Cafcass contributed in 14/15 is as follows:

- Traditional: the model that was formerly stipulated in *Working Together* that principally relies on written reports prepared by each agency. The report is intended to identify single-agency learning with the panel assisting the independent reviewer in identifying multi-agency learning within the overview report.
- SCIE (commonly referred to as the 'systems model'): this relies primarily on 'conversations' between the reviewers and practitioners around key events or periods. The emphasis is on 'learning together' i.e. multi-agency learning.
- Significant Incident Learning Process (SILP): originally designed for cases that fell below the SCR threshold but now sometimes employed within SCRs. The model seems to be similar to SCIE.
- Hybrid: making explicit use of different methods. Typically, this entails a written submission, together with one or more practitioner events that are designed to generate multi-agency learning.

Using the above classification, table 2 sets out the number of the different categories of SCRs to which Cafcass contributed:

Table 2: different categories of SCRs

Methodology	Number
Traditional	12
Hybrid	7
SCIE	4
SILP	2
Not known	1
Total	26

In November 2014 the authors of this report met with the Department of Education to share our concerns about a number of aspects of SCR practice, including: the poor quality of many overview reports; methodologies that lack coherence or that are amended without a clear rationale; an over-reliance within systems-led reviews on 'conversations' and a lack of clarity as to how learning generated by these is to be promoted across participating agencies.

Notwithstanding these concerns (and the substantial investment of resources required by our participation in SCRs) it is evident that Cafcass has derived a great deal of learning from our SCR involvement. During 14/15 we instigated file reviews, undertaken by the National Improvement Service, generally within a working day of notification, and shared with the Head of Service and National Service Director (and subsequently, in summary form, with the Operational Management Team - OMT). These reviews were originally instigated to ensure that we identified immediate learning or actions required in those reviews that used systems models. However, the benefits have been demonstrated across the board as weaknesses are swiftly identified and addressed. Other mechanisms for sharing learning from our SCR submissions include: the cascading of learning down from OMT; the incorporation into training modules; and the annual IMR research.

Examples of specific recommendations/action points derived from Cafcass submissions to SCRs include:

- To review business processes in safe handling of court applications with specific attention to urgent applications to ensure compliance with Child Arrangements Programme (CAP), and to ensure that these are handled safely.
- To review processes in relation to staff self-filing status and ensure that guidance is being adhered to.
- To reinforce, through Operational Management Team, the existing expectation of a higher level of management oversight of casework decisions in respect of staff who are or have been subject to action plans.
- To improve the effectiveness of the operational processes in Work to First Hearing to deliver safe outcomes. This includes reviewing the arrangements of the Duty Officer in responding to all applications, giving attention to 'Urgent and Without Notice' applications; FCAs to receive further briefings on seeking early outcomes on these

applications; complete a review of the 10 most recent 'Urgent and Without Notice' applications against compliance with policy.

Cafcass was asked to contribute to just four Domestic Homicide Reviews in 14/15, and contributed through a factual report to three, the court refusing permission in another case.

Reputational risk

Where our practice is weak, there are two potential sources of reputational damage: within the LSCB that commissions and publishes the report; and within the public domain. The latter risk is much greater where the national media takes an interest in SCR reports. Media interest, at a national level, has been relatively rare though there has been more local media attention. This media interest is managed via the Cafcass Communications team and often involves joint communication strategies with the LSCB. There was one case in 14/15 where Cafcass practice was found to be seriously wanting within our own IMR and within the overview report and plans are in place to address this. Other errors were identified, as set out above, but these did not constitute failures in safeguarding. Cafcass did not suffer serious reputational damage as a consequence of its SCR submissions in 14/15. Indeed, the quality of its SCR submissions (this being an activity in which Cafcass invests substantially from notification through to completion of action plan) may have enhanced its reputation in some respects.

A challenge has been posed by overview reports that are, in draft form, critical of Cafcass through a misunderstanding of our role. As might be expected, this occurs more frequently in private law cases than in public law, as LSCBs are less well-sighted on such matters. In such instances Cafcass rigorously challenges draft reports and has successfully argued for the removal, or at least the re-wording, of unjustified criticism.

To mitigate risk of reputational damage, Cafcass ensures that the key elements of the organisation involved in SCRs – operations, safeguarding team, NIS and Communications – work together and keep each other sighted of the progress of reviews. A database has been set up, shared by the safeguarding team and Communications, which records each review in progress, the perceived risks, the proposed date of publication and so on. Work is currently in progress through OMT to ensure that the relevant Assistant Director/ Head of Service is fully sighted of the draft IMR and signs this to agree its content and the learning. All action points will be tracked and recorded by the safeguarding team, and reported regularly back to OMT.

4 'Getting to good': national quality audit summary report and Ofsted action plan

A national audit of practice was undertaken in November 2014. This looked into matters such as whether the report outlined the voice of the child; practice was child-centred; the child was seen by the practitioner. In those very few cases where the child was not seen, the audit measured the clarity and suitability of the professional judgement provided for this.

The results exceeded targets with a marked rise in cases graded as good, and a marked fall in cases graded as unmet. Specifically, the audit found that:

- Reports in private law were well written, succinct and set out the voice of the child;
- There were many examples of child-centred practice and engagement;
- Effective case plans centred on the child;

- Equality and diversity issues received more attention (compared with previous audits); and there was more focus on vulnerabilities associated with age and witnessing Domestic Violence.

The audit also established that the recommendations from the Ofsted inspection of early 2014 had been met. The recommendations were to:

- Improve the minority of safeguarding letters which are not yet fit for purpose.
- Eliminate poor grammar and typographical errors: the percentage of Good and Met work has improved and a continued focus will increase the level of improvement further.
- Improve effectiveness of efforts to contact parties or where sufficient efforts have been made these should be better recorded.
- Ensure that in all private law casework work begins as early as possible once a family court adviser has been allocated.
- Improve the percentage of Good in Private law, WAFH in a specific service area.
- Improve further the analysis in the report to the court and ensure that all relevant information is pulled through in to the report and based on research: this has been met, especially in terms of greater child engagement.

The national action plan that was developed in relation to Ofsted recommendations has been completed and is now signed-off.

In the light of the positive findings of the national audit (and in line with Ofsted practice) thematic audits will be conducted in 15/16 looking into: the quality of liaison with the IRO; the children's guardian's involvement in any position statements; and the quality of analysis in private law work after first hearing (WAFH), including the use of assessment tools and research.

5 Local Safeguarding Children Boards (LSCBs)

Cafcass is a statutory board partner of each of the 146 LSCBs in England, under s13 (3) of the Children Act 2004. The Cafcass LSCB strategy was defined some three years ago. It has, for the most part, proved effective in maintaining positive relationships with LSCBs without expending a disproportionate amount of resources. The key elements of the strategy are:

- The Head of Service/Assistant Director agrees with the LSCB Chair the appropriate type and level of involvement. This varies from full involvement with a clear role in some, to a watching brief in others.
- Financial contribution to all LSCBs (the contribution has remained at a flat rate of £550 per annum to each LSCB for several years).
- The unit of currency to measure involvement should not be attendance at meetings, but rather the quality of input and engagement. Good communication with the LSCB Chair/ business manager helps to identify gaps in LSCB knowledge and mutual areas of interest.
- Through its experiences of practice and involvement in Local Family Justice Boards Cafcass is well placed to advise LSCBs of developments in family justice.

- Cafcass contributes to s11 audits and annual LSCB reports. Corporate submissions are available to Cafcass managers to assist them in these tasks, together with corporate presentations on developments in private and public law.

The question of how much Cafcass benefits from its membership of LSCBs is a complex one. LSCBs can be a valuable resource. There are no other comparable organisations to fulfil LSCB functions or against which to gauge LSCB effectiveness. However, it is evident from Ofsted inspections and the recently-published research into LSCBs commissioned by the Local Government Association, that a number of LSCBs are struggling to be effective. Pressure on resources, unrealistic expectations and a dissonance between responsibilities and authority can all prove to be problematic. LSCBs' expectations of Cafcass (and probably other agencies) are growing, including requests for additional funding. A common experience in Cafcass is of LSCBs not making best use of their limited resources by conducting, for example, very elaborate s11 audits that have little discernible benefit. It is perhaps inevitable that fundamental questions will be asked about the future of LSCBs, in which case Cafcass is well-placed as a national agency to make an informed contribution to this.

6 Cafcass Research Programme

The research programme is scrutinised in detail by the Research Governance Committee (a sub-committee of the Quality Committee) and approved by the Quality Committee. Cafcass completed five research projects in 2014/15 as follows:

i. Care applications study 2014 (September 2014).
ii. Service user feedback survey (November 2014)
iii. Learning from Cafcass submissions to SCRs (November 2014)
iv. Analysis of rule 16.4 appointments considered by the courts in September 2014 (March 2015)
v. Cafcass study of child and adolescent mental health (March 15)

The learning from the above is disseminated to Cafcass staff through the intranet and Channel C; the Learning, Research and Policy Bulletin; and through incorporation into training modules developed by NIS. The research is also made available (redacted where necessary) to external stakeholders through our website and findings of the above were reported in relevant publications.

Cafcass has also continued to support external researchers including Karen Broadhurst and Judith Harwin's study into repeat care (s31) care applications, and has agreed to support other projects by the same team on the subjects of Supervision Orders and the Family Drug and Alcohol Court. We have agreed to be project partners for research by Judith Masson into the outcomes of children who have been subject of care applications and in 2015-16 we will begin to provide support for this project.

7 Learning and Development

Staff were supported in their learning and development through a range of mechanisms including:

- Direct training: the core induction programme; court skills; 2 day child protection and decision-making; children experiencing domestic violence; giving evidence in court training; legal roadshows etc.

- Training modules hosted on MySkills for individual/team learning, including e-learning on child sexual exploitation, staying safe on-line, introduction to private law, introduction to public law, section 25 secure accommodation etc.

- Short focus learning programmes suitable for delivery at team meetings on: defensible decision making, high conflict contact disputes, static and dynamic risk factors, surrogacy and parental orders, decision making in private law domestic violence cases.

- New programmes have also been commissioned on: trafficking, radicalisation, attachment across cultures, signs of safety, attachment and parenting capacity with a focus on relationship based approaches, neglect, diversity (e.g. an eLearning module on understanding 'deaf parenting', LGBT, FGM and new disability and mental health eLearning modules).

- Membership of Research in Practice and Making Research Count.

- The Learning Log – whereby key learning points derived from complaints, SCRs, audits etc. are disseminated across the organisation.

- The Cafcass library (usage of which has increased year-on-year).

8 Child Exploitation

Cafcass developed a Child Sexual Exploitation (CSE) Strategy, led by three senior managers. The strategy was developed in the light of: Cafcass submissions to serious case reviews (SCRs) on the subject of CSE; a number of high-profile reviews and reports, notably the Independent Inquiry into Child Sexual Exploitation in Rotherham (Jay: 2014); and requests from a number of LSCBs for constituent agencies to submit s11-type audits on their policy and practice in respect of CSE. Alongside these factors was the growing political and social concern surrounding CSE

Key elements included: updating training; developing ambassador and champion roles; making dedicated management time to identify and disseminate learning; establishing through the Electronic Case Management System (ECMS) the prevalence and profile of children known to Cafcass who have been subject to CSE.

More recently the CSE Strategy has developed in to a wider Child Exploitation Strategy, incorporating radicalisation and trafficking in addition to CSE. The rationale for this change was that there is sufficient overlap between the three areas to warrant their consideration within the same strategy i.e. vulnerable children; grooming; exploitation by adults to various ends (financial; sexual, domestic servitude; war etc.). The establishment of a Steering Group based on the current CSE Strategy group with additional participants from the National Improvement Service will enable this work to move forward more consistently. The strategy demonstrates that building learning and skills is a priority area.

9 The Mitigation of Risks derived from Practice

The following are the mechanisms by which practice risks are mitigated:

- The court process: all Cafcass reports to court are scrutinised by judges, magistrates, lawyers and parties to cases themselves. This exposes Cafcass work to far greater scrutiny than other social care organisations, whose scrutiny is primarily internal.
- Managerial oversight: all Cafcass practitioners are supervised in line with the Cafcass supervision policy, and undergo a performance stocktake with their manager on a quarterly basis in the Performance and Learning Review (PLR). In addition to the PLR, there is situational supervision whereby support and advice is available to staff at the point-of-need from Enhanced Practitioners/Service Managers. Case related discussions and decision making is recorded in the case record, either on the Case Plan or in the Contact Log.
- Self-regulation: practitioners are assessed to self-regulate and encouraged to do so by the organisation in various ways. Staff who self-regulate are subject to a framework of compliance which is carried out by their manager.
- Auditing: this is carried out in various ways. There is a programme of national audits, service peer review audits and monthly Assistant Director or Head of Service audits. Further audits can be commissioned if a local manager is concerned or if the National Service Director decides an audit of a local service area or a national audit is required. The level of auditing received positive commendation by Ofsted.
- Datasets: performance is scrutinised every month at the Operational Management Team meeting (OMT). It is also a standing item at every service area management meeting (SAM), and at every team meeting. Staff are able to monitor aspects of their own performance through MyWork. Datasets are used by staff to a far greater extent than ever before. Data tells a story about services including about their safety, quality and timeliness e.g. data on the turnaround time of safeguarding checks.
- Improvement work through line management and NIS. This work takes the form of individual coaching, team or service area learning and development events, and the delivering of training. Improvement work is commissioned by local managers or directed by the Operational Management Team following an identified issue for learning from audits, complaints, SCRs etc.
- Regular reports of the outcomes and learning from SCRs and Domestic Homicide Reviews. These are reported to the Operational Management Team, after which they are cascaded through the meeting structure and via a national learning log which brings together learning from all areas of practice including complaints and audit work.

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30 September 2015