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Joint inspectorates' review of inter-agency arrangements and practice to safeguard and protect children in Pembrokeshire

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CSSIW National Office

Government Buildings
Rhydycar
Merthyr Tydfil
CF48 1UZ

Tel: 0300 062 8800
cssiw@wales.gsi.gov.uk
www.cssiw.org.uk

Joint inspectorates' review of inter-agency arrangements and practice to safeguard and protect children in Pembrokeshire between Her Majesty's Inspectorate of Constabulary (HMIC), Care and Social Services Inspectorate Wales (CSSIW), Estyn, Healthcare Inspectorate Wales (HIW) and Her Majesty's Inspectorate of Probation (HMI Probation).

1. Introduction

1.1. During the CSSIW and Estyn joint investigation into the handling and management of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council in June 2011 concerns emerged about the effectiveness of inter-agency child protection practice. As a result, CSSIW and Estyn held discussions with HMIC and they arranged to undertake a separate joint review of inter-agency child protection practice.

1.2 Following publication of the joint CSSIW and Estyn report of their investigation on 11 August, Gwenda Thomas A.M. the Deputy Minister for Children and Social Services said in a written statement:

"There are questions raised in the report about the quality of joint working to safeguard and protect children. CSSIW and Her Majesty's Inspectorate of Constabulary have begun work on this. I have made it clear that I expect this work to formally involve Estyn and the Healthcare Inspectorate Wales in order that a proper evaluation of the contribution of all agencies is included. It will also need to seek the views of the Wales Audit Office".

1.3 This review has been undertaken by CSSIW, Estyn, HIW, HMIC and HMI Probation. The Wales Audit Office has been kept informed and will use the findings from the review to inform its forthcoming special inspection of Pembrokeshire County Council. The terms of reference are at Appendix 1. This report also draws on the work undertaken by the inspectorates as part of the joint inspection of Local Safeguarding Children Boards (LSCB) carried out earlier this year¹.

2. Inter-agency arrangements to protect children

Partnership working

2.1 Effective interagency arrangements and practice are essential to protect and safeguard children. Good partnership working is usually underpinned by clear, agreed, well understood and effective protocols. Partner agencies and individual

¹ [Joint Inspection of Local Safeguarding Children Boards 2011 - Overview](#) October 2011, (CSSIW, Estyn, HIW, HMIC and HMI Probation) ISBN 978 0 7504 6650 9

practitioners need to be clear about their respective roles and responsibilities. Professionals and practitioners need to be confident and knowledgeable in their work. There needs to be appropriate arrangements in place to support their practice, professional decision making and professional development. This must include effective arrangements for professional challenge and robust systems for quality assuring policy and practice.

The Local Safeguarding Children Board

2.2 While individual agencies each have a responsibility to ensure that appropriate arrangements are in place within their own organisation, the Local Safeguarding Children Board (LSCB) has a key role in ensuring that effective policies and working practices are in place to protect children and that they are properly coordinated and implemented.

Investigating allegations

2.3 While all agencies and practitioners have responsibilities for safeguarding and protecting children, the police and social services have statutory responsibility for investigating allegations of child abuse. In order for them to discharge their statutory responsibility they must have effective arrangements in place for carrying out their work and all other agencies and practitioners must understand and effectively discharge their respective responsibilities.

3. Partnership working - Inter-agency arrangements to protect children in Pembrokeshire

The Local Safeguarding Children Board

3.1 All LSCBs in Wales have adopted the All Wales Child Protection Procedures which set out the working arrangements for applying the relevant legislation which pertains to safeguarding and protecting children.

3.2 In early 2011 Pembrokeshire LSCB members had articulated their understanding of the child protection agenda in a governance document, but were only at an early stage of developing a shared understanding of safeguarding.

Protocol for child protection enquiries

3.3 There is a detailed protocol for joint social services and police and single agency child protection enquiries. This protocol delineates clearly the instances where a single agency or a joint investigation between the police and social services will take place, covering all forms of allegations of harm.

3.4 Staff in social services have a good knowledge and understanding of this protocol. While staff stated that the protocol reflected practice in most child protection cases, it has not been applied correctly in many of the cases where allegations of professional abuse with education were dealt with.

3.5 There is a protocol for the resolution of professional differences that was agreed by the Pembrokeshire LSCB in 2008. The protocol describes a two tier approach for dealing with disputes. The policy has a number of apparent inconsistencies, for example it does not make clear where in social services written records of these differences should be kept, and the specified timescales are unclear. However, this policy had not been used effectively and none of the staff spoken to could demonstrate that they were aware of it..

Operational working relationships

3.6 Partnership working at grass root level, across statutory agencies appears to be working well. Frontline social work staff and the police report good working relationships and enjoy a high level of co-operation in working together in child protection work. The inter-agency child protection process begins with the strategy meeting or discussion and the outcome should be recorded. However, agreed actions and outcomes of decisions made are not always recorded in detail by respective agencies. With regard to the police, for example, this was particularly evident in 'lower level' referrals where a 'no further action' decision is agreed. There were good working relationships reported at frontline level between social services and health service practitioners. However, occasionally there were difficulties in obtaining timely information from general practitioners.

Allegations of professional abuse

3.7 In social services, in cases of alleged professional abuse, a child's file has not always been created, as the child may not have been at risk of harm within their own family., As a consequence, records of professional strategy meetings frequently do not contain the outcomes following actions taken in response to allegations against a professional. Further, as no single agency currently takes the lead to coordinate the feedback from the actions and record the final outcome of action taken about alleged professional abuse, it is difficult to identify failures to carry out agreed actions. This makes it more difficult for partners to challenge one another.

3.8 There is no clear local guidance in place for how strategy meetings and any subsequent action and its outcomes are communicated to other partner agencies who need to know about them. For example, in 14-19 education provision when an alleged incident has been referred and becomes subject to the safeguarding procedures, there is no clear process or policy in place to ensure that all partners involved with the project are made aware that there may be a possible risk to children within that project. This means that children and young people could

continue to be placed in projects which are under investigation and thereby put at risk. Partners are not always informed quickly enough when an investigation has been completed and this may delay any action needed to safeguard children and young people.

3.9 When referrals are received in relation to allegations against professionals, social services convene and chair a strategy meeting, where all the relevant agencies are invited to review the information and make the decisions. Inspectors found that strategy meetings are generally held on time. However, the correct agencies are not always invited to each meeting. This means that relevant information is not always shared and taken into account in determining what action is needed.

Recording meetings

3.10 Minutes of multi-agency strategy meetings are not of a good enough quality and are not circulated in a timely or efficient fashion.. At the time of the review, there was no designated minute taker for strategy meetings and some records were poor; there was no evidence of the recording of professional disputes or professional challenge to decisions. For example, inspectors were made aware of cases when it was reported that challenges had been made in respect of decisions not to suspend staff, but these challenges were not recorded. Risk assessment across all agencies appears to be weak and there is not a sufficient audit trail of risk based discussions taking place at partnership meetings.

3.11 Where professionals in different agencies know each other well, there is a tendency to work informally, which means on occasions agreements are made outside of strategy meetings without informing other agencies or recording what has been agreed or following up action adequately.

Professional challenge and holding agencies to account

3.12 Partner agencies have not been sufficiently robust in holding each other to account in terms of actions agreed. There is little evidence of partners following up agreed actions or examining the outcome of actions, disseminating shared learning or evaluating strategic success.

3.13 When social services staff need to challenge other agencies, they have been well supported by their team managers. However, where social services staff have needed to challenge more senior managers in other local authority departments or partner agencies, they have not been well supported by their own senior managers.

Within social services, relationships with other agencies are subject to the appropriate level of challenge at team manager level. However the lack of support felt by frontline staff from more senior managers within social services can mean

that this challenge has little impact. The authority of the chair of strategy meetings is not well supported by social services and other agencies.

Referrals for allegations of professional abuse

3.15 The social services department receives most referrals for allegations of professional abuse and it has satisfactory systems for handling referrals, i.e. logging, recording and holding strategy meetings. However, the quality of the information received at the time of referral from other agencies is sometimes poor and this can increase the risk of poor decision making.

3.16 One of the main barriers to providing good quality information occurs when partner agencies have procedures that require the professional with information that a child has been harmed to share that information with colleagues in their own agency before making a referral. In some cases, it is then the designated child protection officers in those agencies that then make the referral. This leads to delays in getting information to social services, and also, on occasion, to a distortion in the quality of information delivered.

Threshold of significant harm

3.17 Too often the practice in professional strategy meetings has been to judge cases on a 'threshold of significant harm' which is not appropriate for allegations of abuse or causes of concern about people who work with children. Each case should always be judged on its merits following a robust investigation of what is alleged to have happened.

Responses to allegations of professional abuse

3.18 Generally, the multi-agency response to allegations of professional abuse was not sufficiently child focused. This was highlighted in the earlier joint investigation report by CSSIW and Estyn in relation to handling allegations of abuse against staff in education. From a policing perspective, the response was over balanced towards criminal investigation and adjustments are required to fully consider the needs of the child and the value the police could add to this aspect.

Whistle-blowing policy

3.19 In interview social workers and managers discussed the importance of the local authority's whistle-blowing policy for enabling them to accomplish their work. However, they expressed a singular lack of faith in this policy to protect them, or to assist them in safeguarding and protecting children in Pembrokeshire. The absence of confidence and trust in the process undermines its ability to protect children effectively.

Service level agreements

3.20 Pembrokeshire CYPP and the 14-19 partnership use service level agreements (SLA) and partnership agreements that clearly define the individual responsibilities of partners. These include financial management, quality assurance reporting as well as the requirement for providers to work in accordance with the All Wales Child Protection Procedures. The service level agreements are also explicit in their requirement for providers to comply with all the 'statutory regulations and enactments' relating to the health and safety of pupils.

3.21 The 14-19 partnership includes one project known as 'Engage' which has an SLA with external providers that is particularly clear in its requirements for pupil's safeguarding and wellbeing. However, across the range of other service level agreements used in partnership arrangements there is too much variation in how explicitly it is stated that all staff in contact with children must have current CRB checks, which needs to be addressed. The 14-19 partnership has now begun to use more widely the SLA model used by Engage.

3.22 When commissioning services, the quality of the individual provider's policies and procedures are not always checked robustly enough. There is too much reliance on 'trust', by accepting that the provider's signature on the agreement is sufficient assurance that appropriate measures are in place. Local authority officers who manage service level agreements too frequently lack the confidence to challenge this assumption, and to ask providers to verify that they have actually checked that all staff (including volunteers) have the appropriate CRB checks and verified references in place.

Policies and procedures

3.23 As a result of this review both the Probation Trust and the YOT are checking their policies and procedures to see if they are fit for purpose. If not they will make appropriate amendments.

Health service action

3.24 HIW reviewed the cases of alleged abuse (including potential abuse) involving health service staff during the period 1 April 2007 to 31 March 2011. Hywel Dda Health Board provided records of 9 such cases during this period (which also covers its predecessor organisations prior to the Board being established in October 2009). None of these cases concerned abuse alleged to have been carried out by individuals during the course of their employment. In all cases it was clear that key statutory agencies had been aware of and involved in acting on the allegations. Communication between police forces, social service departments and

the health board (and its predecessors) appears to have taken place as appropriate. In each case either the police and/or social services had brought concerns to the attention of the health body. The necessary policy and procedures appear to have been in place although HIW will be seeking clarification from the Health Board on the management of a few of these cases before reaching its final conclusions.

Multi-agency action

3.25 The 25 cases of alleged professional abuse in education services between 2007 and 2011 which were the subject of joint CSSIW/Estyn investigation have now been subject to review by the local authority and Dyfed Powys police. The outcomes of these reviews have been reported to the inspectorates and these will be followed up by the inspectorates with the respective organisations as appropriate.

4. Improving arrangements and professional practice to safeguard and protect children

4.1 The joint inspection revealed a lack of strategic leadership, which contributed to a collective culture in which it was difficult for any of the individual agencies involved to discharge their responsibilities for safeguarding and protecting children effectively in cases of alleged professional abuse.

4.2 The inspection also identified some positives, however, most notably a willingness to work together between some experienced and committed individual practitioners and professionals. This will provide a good basis on which to strengthen and improve safeguarding and child protection arrangements and practice between agencies. To achieve this aim will require strong joint leadership and support across all agencies including appropriate resourcing.

4.3 While individual agencies are putting in place plans to improve safeguarding and child protection, the LSCB has a crucial role in providing the leadership, vision, plans and oversight to achieve this.

5. Particular attention needs to be given to the following issues:

Multiagency handling of allegations of professional abuse

5.1 In response to all allegations of professional abuse, every agency delivering services to children and young people should ensure that there are robust management arrangements for their work. This includes the delivery and quality

assurance of services, as well as the management oversight of risk assessments. This should always include thorough investigation of the risks associated with a child who makes an allegation, other children using the service and all other staff involved with the allegation.

5.2 As a consequence of the risk assessment appropriate action should be taken to ensure that the child, and any other children are immediately protected from harm.

5.3 All relevant organisations should be invited to strategy meetings relating to professional abuse.

5.4 The record keeping for all cases should be clear, accurate and detailed. Records must include explanations for decisions and any disagreements between agencies about the decisions recorded.

Recruitment and training

5.5 All staff at all levels in all organisations should undertake joint child protection training at a level appropriate to their role, which includes the identification of child abuse by professionals, clarity about subsequent action and whistle-blowing. This training should be evaluated to ensure that it is effective.

5.6 All organisations should ensure that their recruitment and employment practices are compliant with the existing legislation and guidance and are of the highest quality to safeguard and protect children.

5.7 Where the delivery of work with children is sub-contracted or subject to a partnership agreement or similar, all organisations should ensure proper child protection practices, including recruitment, employment and operational work. These expectations should be included in contractual agreements and monitored by the commissioning agency.

Local Safeguarding Children Board

5.8 The LSCB should end the practice of judging allegations of professional abuse against a 'threshold of significant harm', before undertaking a robust investigation of what is alleged to have happened.

5.9 The LSCB should ensure that the chair of all child protection strategy meetings has the appropriate level of seniority and that the support required to fulfil this role

is provided to the chair to ensure that they are enabled to effectively discharge their responsibilities without interference.

5.10 The LSCB and individual agencies should ensure that the child's voice is heard, through a variety of opportunities and over time, that these are collated, analysed, openly reported and acted on.

5.11 The LSCB should ensure that effective whistle-blowing procedures are in place in all agencies and take action where there is evidence that these are not working properly.

5.12 The chair of the LSCB and all senior managers in the component organisations should ensure that the core functions of the LSCB are fulfilled, to achieve their overall responsibility to 'co-operate and safeguard and promote the welfare of children in that locality and for ensuring the effectiveness of what they do'.

5.13 Every case of alleged professional abuse should be reported to the LSCB. The LSCB should rigorously review the outcome of each case to ensure that all aspects have been fully identified and acted on appropriately. This should include identifying risks posed to other children by staff against whom allegations have been made and any other staff where there may be concerns about their ability to protect children...

Planned Improvements

5.14 The structure and leadership of child protection in the Dyfed Powys Police is due to change in October 2011 and this is viewed positively by HMIC. The new leadership will have a better understanding of the issues being managed, and the new central recording facility is intended to create more accurate recording, consistency over thresholds/ initial risk assessments and improvements in the quality of data entries.

5.15 The local authority has an improvement plan in place to address the issues identified in the CSSIW/Estyn joint investigation follow up.

5.16 The relevant inspectorates will be following up issues identified in this joint review with individual agencies as necessary. In the spring of 2012 the joint inspectorates will conduct a follow up review of inter-agency arrangements to

safeguard and protect children to determine the progress made in implementing improvement plans and improving practice.

Appendix 1

Terms of reference

Joint inspectorate review of inter-agency arrangements and practice to safeguard and protect children in Pembrokeshire between Her Majesty's Inspectorate of Constabulary (HMIC), Care and Social Services Inspectorate Wales (CSSIW), Estyn, Healthcare Inspectorate Wales (HIW) and Her Majesty's Inspectorate of Probation (HMIP).

This document sets out the approach that the inspectorates will take in conducting this work.

HMIC will confine its review to these areas of the safeguarding arrangements that are directly affected by the actions of Dyfed Powys Police (DPP). The proposed methodology by HMIC would be as follows:

- An examination of national standards relating to child protection.
- A review of force/local standards relating to child protection.
- Consider the issues raised by CSSIW and Estyn against national/local standards
- Undertake fieldwork to determine whether standards have been met

CSSIW will build on the work already undertaken in its joint investigation with Estyn in Pembrokeshire in examining a sample of 14 of the 25 cases of alleged abuse by staff in education services, focussing specifically on the effectiveness of multiagency working arrangements with statutory partners in the handling of allegations of professional abuse from the education department. Specifically:

- The policies in place for furthering multiagency working in child protection procedures, and resolving disputes.
- The referrals process for allegations against professionals
- The effectiveness of multiagency decision making following referral
- The robustness of investigations/joint investigations (including the voice of the child)
- The multiagency cooperation in ensuring good outcomes for children and young people following an investigation.

The field work will comprise one day of interviews with frontline staff and managers within children's social services.

Estyn will examine any reported cases of 'professional abuse' for the period April 2007 to September 2011, in youth support services and 14-19 off-site education provision, not already identified in the previous investigation. In order to follow through the multi-agency aspects in the management of safeguarding in Pembrokeshire, and in the light of the shortcomings and recommendations included in the Estyn youth support services

inspection of 2008, the investigation of multi agency work to protect children in Pembrokeshire will look at how well safeguarding is managed in partnership working in youth support services and 14-19 provision.

Estyn will explore with the CYPP, 14-19 partnership, local authority, PAVS and its main partners, how well they ensure partnership based projects are properly covered by adequate policies and practices which impact on safeguarding children. These will include arrangements to ensure partners have policies in place for child protection, safe recruitment, and lone working with children; how thoroughly they undertake safe recruitment practices, CRB checks, and take up references; how well they risk assess hazardous and off site activities etc. Estyn will wish to interview:

- members of the PAVS management group with responsibilities for safeguarding issues, and safeguarding training;
- local authority youth service officers with responsibility for setting up, managing and quality assuring joint working with the voluntary sector;
- local authority officers with responsibility for setting up 14-19 education provision outside of schools and the FE college;
- members of the 14-19 partnership with safeguarding lead responsibilities;
- managers within the voluntary sector where professional abuse has been identified; and
- managers within 14-19 education provision outside of schools where professional abuse has been identified.

HIW will:

- examine the role of health professionals in a sample of the 25 cases highlighted by CSSIW and Estyn as being of concern.
- undertake a review of the management and handling of cases of alleged abuse of children by healthcare staff reported to Hywel Dda Health Board or its predecessor organisations between 1 April 2007 and 31 March 2011.
- review records of attendances at A&E and minor injuries units (for the period 1 April 2007 and 31 March 2011) to identify if there were any trends that should have highlighted issues or concerns and upon which healthcare staff should have taken action.

HMI Probation will:

Examine any reported cases of 'professional abuse' (against children or young people under 18 years) for the period April 2007 to September 2011 in the Youth Offending

Service and Probation Service in Pembrokeshire, or agencies contracted to deliver services on their behalf,

General

The inspectorates will also consider the outcome of the joint review of the 25 cases of alleged professional abuse in schools and education services between 2007 and 2011 being undertaken by Pembrokeshire County Council and Dyfed Powys Police force.

The inspectorates will publish a joint report that will identify any areas for improvement to the working arrangements between agencies, areas of good practice and provide guidance to agencies to make improvements to working practices where necessary.

If during the course of this review, matters of concern relating to individual cases become known to the inspectorates these will be referred to the relevant agencies to be actioned.

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