



city & hackney  
safeguarding  
children board

# CHSCB Case Audits Hackney 2015-16

***The CHSCB multi-agency case auditing has identified numerous examples of positive safeguarding practice being undertaken by the partnership. Lessons have also been identified that have led to tangible improvements.***

Systematic auditing allows the CHSCB to deliver one of the best learning opportunities for front-line workers; directly engaging them in a process that reflects upon, assesses and measures the quality of professional practice. The CHSCB operates a consistent and regular 6 monthly multi-agency case file audit process, which is carried out across the City of London and Hackney.

# Early Help

## Strengths

- The cases audited evidenced **clear examples of escalation**.
- There was evidence of professionals considering **long-term planning** for young people with identified vulnerabilities.
- There was evidence of evidence of **positive multi-agency work** with good packages of support coordinated through the MAT process. This helped families engage in universal services and improve outcomes for children.

## Lessons

### Identification of the lead professional

In some cases with multi-agency involvement, the lead professional was not easily identifiable from case notes.

**Is it clear from your case files who the lead professional is and how to contact them?**

### Information Sharing

The cases audited indicated issues around **information sharing** with agencies not always being informed of case developments or when services ended involvement.

**Are you familiar with [information sharing](#) guidance?**

**If there is a change in your case, do you share within your agency and with appropriate partner agencies?**

**Are you aware of the CHSCB Escalation Policy? If not, read it [here](#) – it's important!**

### Early naming of neglect

The audits identified the importance of the early naming of neglect to help professionals focus on identifying potential risk. Professionals with concerns are encouraged to document through chronology work, use SMART plans with clear, child-focused actions and share information with appropriate agencies.

**Are you familiar with the signs and symptoms of [neglect](#)?**

**If neglect is identified as a potential risk, do you use chronology work alongside information sharing with relevant agencies to build up a picture of concerns?**

**Are your plans SMART and focused on the needs of the child? Are you clear on next steps if outcomes are not met?**

### **Importance of supervision**

The audits identified the importance of supervision to help professionals think through safeguarding concerns and responses.

**Do you talk with a supervisor or colleague(s) to help think through concerns or situations where the relationship with the parent is detracting from focus on the child?**

### **Use of interpreters**

The audits identified the potential risk in using family members to interpret – important for practitioners to consider the context when using interpreters

**Do you use professional interpreters or do you consider the context of the concern if you have to use a family member?**

# Journey of the Child

## Strengths

### Case 1 – Domestic Violence Issues

- The case audited evidenced **persistence in promoting parental engagement** by all agencies.
- Evidence of **good inter-agency liaison and safety planning** in domestic violence cases.
- Professional's **awareness of risk** throughout the step down process (evidenced as new concerns appropriately escalated).
- Evidence of **professional debate** at Initial Child Protection Conferences with professionals having opportunity to discuss concerns and consensus reached.
- **Proactive response** by the GP as additional information sought to provide the context of issues.

### Case 2 – Mental Health Issues

- The case audited evidenced **good engagement with family and multi-agency liaison** as a range of professionals invited to the mental health discharge meeting.
- The case evidenced **impact of multi-agency response** as parental mental health has improved and a good package of support in place.
- Evidence of **rapid response to concerns and insightful practice** by GP and Mental Health Services who recognised the impact of parental mental health on the child.
- Evidence of School **proactively seeking information** where concerns were noted.

## Lessons

### Context of concerns

The cases audited highlighted that when sharing or requesting information, it is important to give the safeguarding context to enable professionals to provide a proportionate response.

**Do you appropriately communicate the safeguarding context when requesting information from other agencies?**

### Exploration of cultural issues

In one case, more *documented* work was needed to explore cultural issues around honour based violence. This is especially important if the worker and

service user are from a similar background.

**Do you explore cultural issues with parents and children/young people? If so, do you record clearly in the case file as a reference for other workers?**

**Transfer of school files**

In one case, the receiving school was not aware of safeguarding concerns as had not received the transfer files.

**Schools – Do you have a system in place to track transfer of files? Do you monitor and escalate if files are not received in a timely manner?**

**Are you aware of the CHSCB Escalation Policy? If not, read it [here](#) – it's important!**

**Safeguarding concerns for disabled children**

In one case it was noted that a Child with Disabilities Social Worker role was to review care packages on an annual basis.

**If you have safeguarding concerns about a disabled child, a referral to Children's Social Care is needed! Don't assume regular contact with the child.**