

# Excellence and Evidence – Making the Difference Conference 2010

## Safeguarding

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June 2010

Department for  
**Education**

# Why are we here today?

- **Explore safeguarding issues & priorities**
- **Consider what safeguarding means to you**
- **Explore practice issues arising from Serious Case Reviews**

# Context...

- **New coalition Government**
- **Economic climate**
- Heightened awareness of vulnerable children → increased demand:
  - Referrals  2%
  - initial assessments  9%
  - core assessments  15%.
  - Care Demand 2009-10  34% compared to 2008-2009 (CAFCASS).
  - children with child protection plans  11%
- **Higher expectations of services, more authorities in intervention**
- **Early intervention – the challenge and the solution**

# Cross - cutting Safeguarding Issues and Priorities

## Keeping the child in focus

- **Munro Review:**  
**‘Review of Child Protection – Better Frontline Services to Protect Children’**

### Key Question

*‘what helps professionals make the best judgements they can to protect a vulnerable child?’*

# Cross-cutting Safeguarding Issues and Priorities

- **Underpinned by the following 3 principles:**
  - **Early intervention**
  - **Trusting professionals & removing bureaucracy**
  - **Transparency and accountability.**
  
- **Aim for Social Work:**
  - **Clarity of responsibilities & accountabilities**
  - **Confidence to challenge parents & supported by the system to do so**

# Early Intervention

How can interaction between social work teams and universal services for children & families be improved?

How can Sure Start Children's Centres and Health Visitors make sure that families who need the specialist input of Social Workers are identified effectively?

What are the barriers to consistently good social work practice?

How can other agencies help social workers undertake more effective practice?

# Trusting professionals, removing bureaucracy

How could regulation be simplified and bureaucracy reduced ?

What are better ways of using data to improve practice?

How can social workers be supported to have the confidence to challenge difficult families when that is what is needed to protect children?

How have targets got in the way of good practice?

What can be learnt by what happens in other countries?

How could social workers be given greater professional freedom?

How could councils most effectively share best practice with each other?

What role might Social Work Practices, new models of social work delivery and volunteer social workers play?

# Greater transparency and accountability

How can risk be managed so that agencies do not develop a blame culture and their focus remains on protecting children?

How can greater transparency in the system be achieved in a way which commands public confidence and protects the privacy and welfare of vulnerable children and their families?

Is there a role for a Chief Social Worker?

What approaches to inspection would better capture the quality of frontline practice and lead to better services for children?

How could the system champion the profession, raising its status?

# Professor Munro's review will also consider

How could  
SCR's be  
strengthened?

Are there alternative ways  
of learning from  
experience that could be  
more effective and  
efficient?

What might be learnt  
from other sectors?

# Timescales

Evidence report end  
of September 2010



Interim report in  
January 2011



Final report in April  
2011

# Serious Case Reviews

**It is the Government's intention that LSCBs will publish suitably anonymised SCRs initiated on or after 10 June 2010.**

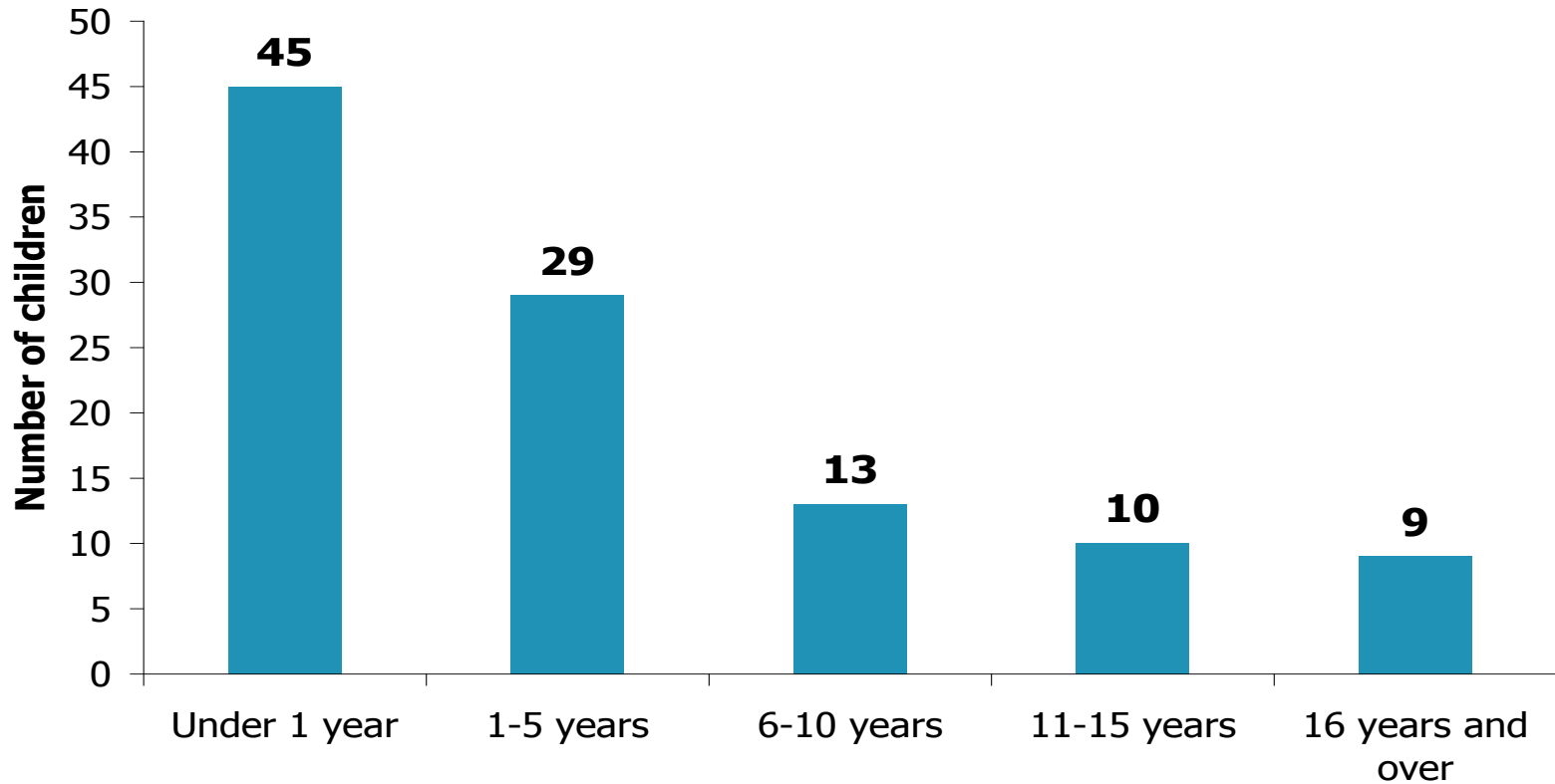
- Overview reports should be published together with executive summaries unless there are compelling reasons relating to the welfare of any children directly concerned in the case for this not to happen.
- Overview report and executive summary should be anonymised and should not contain identifying details
- All references and publication of executive summary in chapter 8 WTSC should be read as meaning publication of both
- The content of the SCR should be suitably anonymised to protect the identity of children, relevant family members and others and should comply with the Data Protection Act 1998.

# Learning lessons from serious case reviews: interim report 2009 –10

- Evaluated serious case reviews within period **1 April to 30 September 2009**
- **85** serious case reviews (**106** children analysed).
- Highlights improvement in the proportion of reviews that Ofsted judged to be adequate or better, and a reduction in the proportion judged to be inadequate:
  - 30 good
  - 38 adequate
  - 17 inadequate,

[www.ofsted.gov.uk](http://www.ofsted.gov.uk) , 'Learning the lessons from Serious Case Reviews, Interim Report 2009 – 10.

# Ages of 106 Children



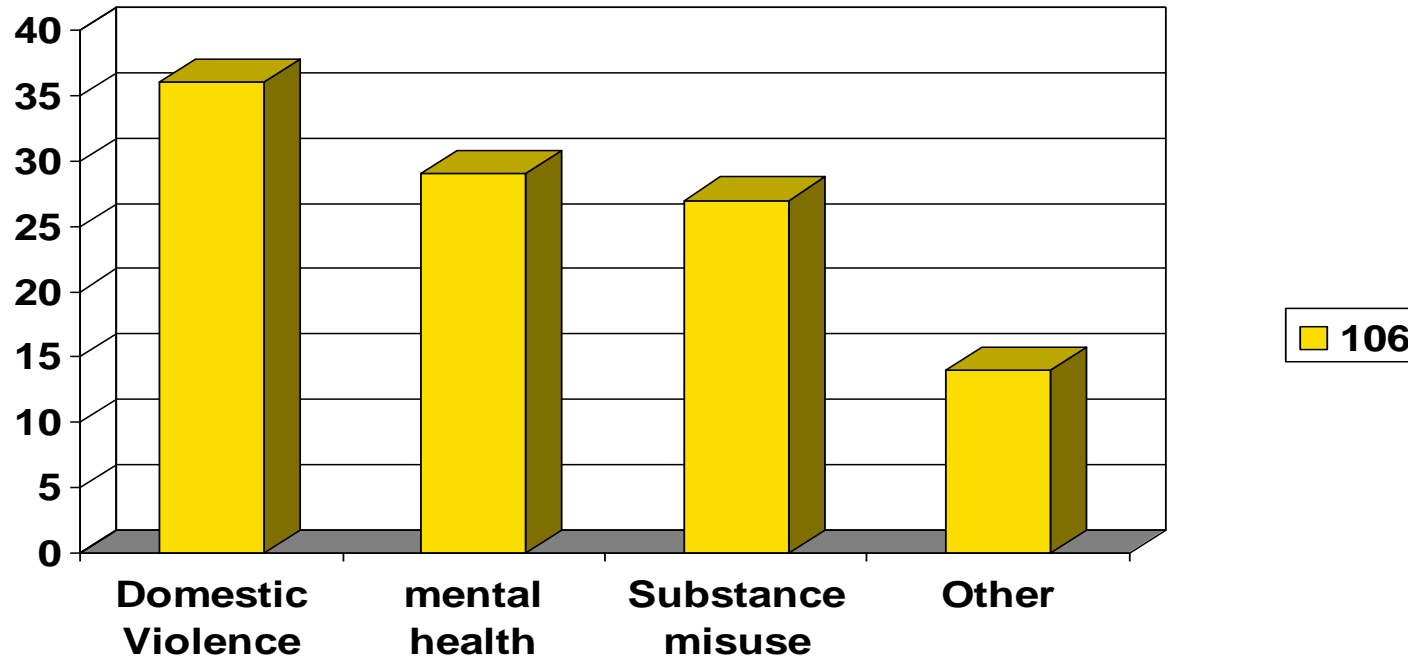
From Ofsted (2010)

# Key findings

- Physical abuse most common characteristic of the incidents reviewed.
- Minority of children, 41 / 106 in contact with social care services at time of the incident.
- Common finding: lack of complete picture of the child's family and a full record of the concerns. Holistic assessments of risk were not made routinely.
- Sometimes a lack of focus on the child when working with the family
- Examples of poor communication and information sharing between agencies

# Family Characteristics

The incidence of these factors was more frequent in cases where children had died than in non-fatal cases.



# Practice messages - general

- Poor communication and information sharing
- Poor assessments → inadequate plans
- Referrals not always followed up rigorously
- Universal services not working collaboratively; focusing on presenting issue rather than taking an wider overview
- Professionals not considering the child's daily experience of life
- Inadequate management oversight & decision making & a failure to implement & ensure good practice

# Practice messages - health

- Signs and symptoms of possible abuse or risk noted but not acted upon
- Poor communication within and between health services
- Poor management oversight/clinical supervision → a failure to identify concerns or provide professional challenge
- Bruising to non-ambulant babies not challenged
- Injuries to babies taken to hospital treated as single events
- Adult focused services not taking account of impact of parental needs on risk and parenting capacity

# Practice messages - education

- Majority of children not school age
- CAF process not embedded
- Safeguarding training provided but processes not always followed
- Named safeguarding leads were not always in place
- When undertaking the SCR, it became evident that the records of teenage parents to examine their childhood histories, were frequently unavailable and hampered proper evaluation

# Practice messages: Children's Social Care

- Limited front line management capacity and overview of work quality more frequent than failure to allocate
- Thresholds for eligibility for services high
- Good chronologies not systematically available
- Difficulty in identifying chronic neglect, over optimistic view re quality of a child's life & whether sufficient change had been achieved and sustained
- Focus on adult needs and loss of focus on child
- Response to domestic violence referrals varied

# Practice messages: police

- Domestic violence was a significant factor in **36/106** children.
- Wide variation in recording of incidents of DV and in identifying children at risk of harm.
- Varied protocols and practices for sharing information with children's social care after attendance at DV incidents
- Variation in ability of police to access information where the children were the subject to a child protection plan

# Finally

- Most children and families are known to a range of agencies
- We all have shared accountability for protection of children
- We can do this by
  - providing effective services for the most vulnerable as early as possible
  - recognising & addressing risk factors
  - sharing information and working together.

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