

**7 Minute Briefing: Learning from Education Audit**

**Independent Chairs**

June 2022



 **1. Introduction**

**In January 2021 the QA services was asked to review several children that had historically been referred by education professionals as children to be concerned about. For the majority of the children neglectful care was the primary risk factor, and within this a lack of change in their experiences of being parented resulting in repeat referrals.**

**34 children were reviewed with 10 receiving a deep dive audit. Children’s records were assessed using a RAG rating. 15 of the 34 children were escalated to managers. 6 of the children’s cases were reopened, of which 2 progressed to ICPC.**

**A joint education review action plan was finalised in March 2022.**

**6. Must Dos:**

* **Service co-ordinators to continue to be alerted to children being presented at ICPC for a second time and liaise with service managers to consider need for a legal view.**
* **Service co-ordinators continue to review plans over 18 months to be confident change is sustained before step down**
* **Where dissent takes place for a child who steps down from a CP plan, the independent chair would then chair the next two child in need meetings.**

**5. Key Learning:**

* **Over reliance on parent’s self-report as well as professional optimism meant that children did not have the right support and the risks of harm not fully challenged and assessed.**
* **Chronic neglect may lead to circumstances where families need support at specific points in the child’s journey as the capacity to change and sustain this was limited.**
* **Multiple workers and turnover of staff should be considered a complicating factor as key information can be missed in the process of handover and momentum being lost.**
* **Relationships with family’s were not sufficiently established to support good engagement at step down (often due to complex history with professionals) which meant consent was withdrawn and opportunity for further work was missed**

 **7. Must Dos continued:**

* **Service co-ordinators have oversight of recommendations to step down children at first CP conference to ensure all step downs are appropriate and evidence that change has been sustained.**
* **All conferences will have an explanation as to the importance as well as the process of formally dissenting and to review at the end where there is a split decision.**
* **Service co-ordinators complete routine practice observations and target children on plans for neglect for more than 12 months as well as children subject to repeat CP plans.**
* **Any child where neglect is the identified issue needs a GCP2 completed.**
* **Multi-agency chronologies will be completed for all children who meet the parameters of the joint education legacy review.**

 **2. Key Findings**

 **Areas of Development**

* **There was variability in the quality of the recording of the child’s voice following visits, and reduction in overall quality of visit during Covid19.**
* **There was limited evidence of tools to assess neglect, such as GCP2.**
* **Assessments did not fully analyse the child’s history (including repeat referrals) which led to over optimism in parental capacity to make and sustain change.**
* **Minutes for core group meetings did not evidence challenge from the multi-agency when it was evident the plan was not progressing at pace. Use of the partnership to escalate or dissent at conferences was not clear.**
* **Supervision and challenge from independent chairs was not well utilised to demonstrate grip and drive forward plans.**

**4. Key Learning:**

* **The concerns about the children escalated by education colleagues were agreed and upheld.**
* **There were missed opportunities for the multi-agency group to assess and fully analyse history, capacity to sustain change, impact of cumulative harm due to differences in opinion.**
* **There was a lack of focus of neglect as the primary issue. Other issues (such as domestic violence or substance misuse) took priority and then the impact of cumulative harm caused by neglect did not get fully assessed.**
* **Threshold decisions and the need for further intervention were often based on current presentation and/or loss of consent to work with the family under CiN or Early help. This resulted in repeat referrals and start again approach.**

**3. Findings continued**

 **Good Practice**

* **Timely visits to children.**
* **Good attendance at multi agency meetings. Partner agencies were engaged and had good knowledge of the children they were working with.**
* **For the mjority of children there were appropriate & timely responses to immediate safety and wellbeing issues linked to escalating risks.**