Norfolk Safeguarding Children Board

Serious Case Review Action Plans

Case P – April 2016

1. Introduction

The Norfolk Safeguarding Children Board (NSCB) has a duty under Working Together 2015 to conduct Serious Case Reviews (SCRs) under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006. Regulation 5(1) (e) and (2) set out the LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; **and**
(b) **either** —
(i) the child has died; **or**
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Case P is the fifth SCR to be published by Norfolk in the last two years. The NSCB is committed to maximise learning from these cases and minimise the risks of similar cases emerging by addressing frontline practice. Our SCR processes were noted as 'clear and effective' in the Ofsted LSCB Review, published in Oct 2015, including the effective dissemination of learning (paragraphs 156 and 157).

All SCRs are signed off with a set of recommendations against which the Board implements actions for improvement. With a high volume of cases, there is a danger that the Board is distracted by individual recommendations, therefore, with the publication of Case P, partners have taken a different approach to action planning. There are themes emerging from this case that chime with both other local SCRs as well as national learning. To ensure that we effectively move forward on the recommendations and make Norfolk a safer place for children and young people to live and grow up, we have taken a step back to get an overview of the lessons in their wider context in order to provide a robust, forward thinking strategic response.

2. Norfolk Safeguarding Children Board's Strategic Response

Case P resonates with identified Board priorities, i.e. the issue of child sexual abuse. This is the case of a vulnerable young girl who was abused by her mother's partner and agencies failed to take the necessary steps to safeguard her. Child sexual abuse is recognised as a challenging issue nationally and the recent Inquiry into Child Sexual Abuse in the Family Environment, published by the Office of Children's Commissioner (Oct 2015) clearly states that the starting point to address this issue is not about professional failure:

> *A system which waits for children to tell someone cannot be effective. It is clear that professionals working with children and the systems they work within must be better equipped to identify and act on the signs and symptoms of abuse.*

The Board's strategic response to this case therefore must address the wider systemic learning.

3: The Cornerstones of Systemic Learning: Recurring Themes

When considering the recommendations from Case P, the agencies involved were required to ask themselves two things:

- How likely is this to happen again? And
- What can we do to ensure that all reasonable steps are taken to prevent children from being abused in this way in the future?

What is evident is that there are recurring themes from the lessons learned in Serious Case Reviews.

- **Professional curiosity** – linked to assessment, analysis and supervision to improve reflective practice

- **Fora for discussion** – where and how do we share information? (e.g. the Multi-Agency Strategic Hub/MASH, strategy discussions, conferences, phone calls, etc)

- **Collaborative working and decision making** – ensuring professionals come together to build a complete picture so that children get the right service at the right time

- **Ownership and accountability** – the organisational context, balancing instability with containment, ensuring management grip and supporting the workforce to feel safe to safeguard

These are described as the four cornerstones of learning and at the centre of each SCR is case specific learning linked to the child's lived experience, as illustrated below:

With this in mind we have drawn up the action plan for Case P against these thematic areas.

The Voice of the Child

The Lead Reviewer and NSCB Business Manager met with Child P during the review and shared the final report with her prior to publication.

4. Recommendations and Next Steps

The recommendations coming out of this review, as well as historic review activity, have been taken into account in the published strategy for identifying and tackling child sexual abuse.

Recommendations from all SCRs are monitored through a composite action plan, which is currently being redrafted to align with our new approach to systemic learning described above.

With all these actions there is an expectation that there are mechanisms in place to both achieve the changes required and to disseminate the learning.

The mechanisms for achieving change are through:

- Policy & Procedure
- Workforce development and training
- Locality working/sector specific working – through the NSCB's Local Safeguarding Children Groups and the Education, Health and District Council Advisory Groups
- Audit and monitoring: testing impact of actions

We will ensure that the lessons reach the frontline through:

- The Local Safeguarding Children Groups (LSCGs) and sector specific Advisory Groups (Health, Education and District Councils)
- Children's Services colloquium & partners' internal communication systems
- The NSCB website and Best Practice events
- Conferences/workshops linked to the Board's priorities

Learning is intrinsic to the NSCB's overarching strategic framework, which encompasses Signs of Safety, Early Help and our revised approach to the Threshold Guide.

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THEME 1: Professional Curiosity

CONTEXT AND SUMMARY	Recommendation
MULTI-AGENCY: Uninformed naivety about • Proportion of each week that a known Sex Offender was resident in the household • Unsupervised time spent with child P • Ability or motivation of mother to protect her daughter from abuse (of which she and others in the extended family had been victims)	Workshops should be provided to all front-line social workers, managers and relevant other professionals that acknowledge the 'modus operandi' of offenders, disruption methodology and risk management. (Recommendation 2)
EDUCATION: The vulnerability of child P was compounded by a number of other systemic factors, including Ineffective practice in the management of absence from school. Attendance services did not work collaboratively with partners to understand the underlying factors contributing to absence.	The local authority should audit the 'Attendance Service' casework in order to evaluate: • Recording • Quality of plans including timescales • Supervision • Outcomes for the child • Case closure (Recommendation 4)
	Supervision arrangements for attendance support and enforcement officers (AEOs – known as 'attendance improvement officers' throughout the period of review) should be reviewed and strengthened so that: • Staff are better supported to consider case history and be more reflective in their practice • There is management accountability for all casework • Record keeping should demonstrate that case history has been considered and impacted upon decision making in supervision Achievement will require review of current policy and training of relevant managers / supervisors. (Recommendation 6)
	When the above changes to policy and procedures have been made, training (focusing on the learning from this case and implications for management of school attendance) should be provided to Attendance Service staff and offered to 'attendance leads' in schools. (Recommendation 7)

THEME 1: Professional Curiosity, continued	
CONTEXT AND SUMMARY	**Recommendation**
COMMUNITY HEALTH: Following disclosure of domestic abuse to the school nurse, there is no evidence liaison between the school nurse and the school to explore and gain further understanding about the impact of this violent incident on Child P .	Specialist training on the impact of domestic abuse should be commissioned and provided to school nurses and should include risk management / professional analysis. (Recommendation 9)
GP: There was a variable level of curiosity when seeing P and her mother. Whilst there was an awareness of mother's health difficulties, relationship difficulties and P's presentations these were not considered together in terms of mum's ability to meet P's needs and possible neglectful parenting.	GP Practices should routinely discuss at clinical meetings the cases of children who have high consultation rates and record outcomes of discussions on the child's record. (Recommendation 11)
CHILDREN'S SERVICES: Referrals were made and responded to and the case was always closed. Further comment would have highlighted the lack of appropriately challenging and in depth training available to front line staff in relation to sex offenders, their modus operandi and any contra indications from the adult's childhood and experience of family.	Mandatory specialist training should be commissioned and provided to all operational social workers and managers about working with adults known to pose a risk to children. (Recommendation 16) *The effectiveness of the above changes can be assured by means of management overview, supervision, appraisal and case audits*

THEME 2: Fora for discussion and information sharing	
CONTEXT AND SUMMARY	**Recommendation**
EDUCATION: Fast-track interventions did not bring about any sustained improvements in Child P's attendance.	The 'County Attendance Guidance and Pro-forma for 'fast-track' meetings should be revised so as to ensure that: • Consideration is given to family history and past Service involvement • All plans to address poor school attendance identify and establish clear, understandable and measurable outcomes • Any medical evidence offered is reviewed to consider whether it justifies the level of absence • If there is evidence to suggest that medical needs are the cause of poor school attendance, a further plan should be developed to address those needs at the point of closing a 'fast track' case • The reason for case closure is clearly recorded in the minutes of the School Attendance panel (Recommendation 5)
EDUCATION: • The existence of medical evidence appears to have been a key driver influencing the decision not to proceed with more formal legal action; this is understandable given the legal framework for the management of absence from school but in the absence of an alternative plan, Child P was left vulnerable to educational disadvantage. • In order to ensure that vulnerable pupils are appropriately supported at transition, all schools should ensure that relevant safeguarding information is passed to the receiving school in line with statutory guidance.	Further guidance should be developed for schools to inform and facilitate the support of vulnerable pupils by: • Recording all communication with other agencies • Implementing communication systems within school so that all relevant safeguarding and attendance information is shared with staff who are working with a pupil This guidance should be disseminated to all schools and be included in training for 'designated safeguarding leads'. (Recommendation 8)
CHILDREN'S SERVICES: The written agreements all state that an ICPC was an outcome if Child P and the perpetrator were left unsupervised or alone. These assertions was never followed through and there was little or no thought as to what the status of a written agreement would be in a case that was closed.	The extent of compliance with the current policy on the use of 'written agreements' should be evaluated by means of inclusion of that issue in ongoing practice audits. (Recommendation 17)

THEME 3: Collaborative working and decision making	
CONTEXT AND SUMMARY	**Recommendation**
MULTI-AGENCY: A considered discussion about the parentally-asserted versus professionally-provided medical evidence to support school absence would have clarified that there was a need to better understand the way in which child P's family operated. Management of school attendance offers an example of the fragmentation of information.	NSCB should commission the development of a protocol and associated guidance for best practice in managing absences from school reported by parents to be for health-related reasons. (Recommendation 1)
COMMUNITY HEALTH: C39ds (police reports) were either not received or the information was received and not recorded on the SystmOne records.	Local guidance should be developed for operational school nurse managers and school nurses to underpin safe practice in responding to notifications from Police about domestic abuse where children have been identified. (Recommendation 10)
GP: GPs had information on domestic violence in the household and mum's lack of engagement with support for P from letters received. This information does not appear to have been considered in terms of impact on P and was lost in filed letters. If the information on DV had been on the summary of mum's and P's record it would have been more visible at each consultation.	Practice safeguarding policies should detail processes for responding to 'safeguarding enquiries' including sharing (with all relevant staff) of relevant information about parents and other household members, information about the child and should also include recording of risks to the child on her/his record. (Recommendation 12)

THEME 4: Ownership, Accountability and Management Grip	
CONTEXT AND SUMMARY	**Recommendation**
NSCB: The unplanned unavailability of allocated social workers following child P's allegations left her with no reliable individual to protect her and vulnerable to further abuse by step-father. In consequence of re-structuring, children and their families receive help, protection and looked after services from a single head of social work bringing about a cohesive and consistent delivery of functions. This requires testing by the Board.	NSCB should seek an assurance from Children's Social Care that its systems are now sufficiently efficient so as to ensure that a manager's decision to initiate an child protection conference cannot be 'lost' even if the staff allocated to the case are absent through illness or any other reason. (Recommendation 3)
GP: Some of the GPs were aware of incidents of violence in the relationship between mother and step-father. This information was not recorded on the summary of either P's record or mum's record so would not have been readily visible to anyone seeing P or her mum at a later date.	Notifications from A&E or other sources indicating that an individual has been injured as a result of domestic abuse should be recorded on the patient's records summary, and should also be recorded on the summary of children in the household (which for 'SystmOne' users is on the 'safeguarding template). (Recommendation 13)
GP: "Behaviour problems" referred to CAMHS "re ADHD", were then redirected to Family Solutions (Tier 2 CAMHS service). Mum did not accept the advice provided. At this point a conversation between Family Solutions and the GP as referrer would have been useful to assess the impact on P of mum not accepting advice, being stressed and hitting P.	Practices should have robust systems to ensure that notifications of discharge of children from CAMHS Tier 2 or other services because of parental non-engagement, trigger a re-assessment of the child's welfare and needs and any relevant follow-up. (Recommendation 14)
CHILDREN'S SERVICES: Learning from this case must ensure that all staff working with children who have been sexually abused or who are children living with adults known to pose a risk to children must be fully equipped to identify and appropriately risk assess the situation thus enabling them to better contribute to children's planning.	All relevant staff must be reminded of the information and guidance (Norfolk Safeguarding Children Board Policy Manual section 9.1) to support the management of risk posed by individuals with convictions against children. (Recommendation 16)

Achieving change through policy and procedure					
NSCB Strategic Response: What difference do we expect to see? • Policies and procedures provide robust guidance to support frontline staff manage child sexual abuse cases and understand the risks posed by known sex offenders • Health and education improve the way they work together to manage health related attendance issues • Training materials updated to reflect policy change					
Rec No.	**THEME**	**ACTIONS**	**Evidence/Mechanism**	**Owner**	**Timescales**
1	**COLLABORATIVE WORKING & DECISION MAKING**	NSCB to develop a protocol and associated guidance for best practice in managing absences from school reported by parents to be for health-related reasons	Protocol and guidance in place	NSCB Business Manager & Chairs of Education & Health Advisory Group	May 2016
2	**PROF CURIOSITY**	NSCB to review child sexual abuse policy and strategy to promote at CSA best practice event • Probation, Children's Services, Education, Police and Health representatives, with CSA Strategic Lead, review policy relating to known sex offenders to ensure that their 'modus operandi' and learning from this case is brought forward. • Training materials updated to reflect any policy change	• Policy review • Training material updated	NSCB Business Manager & CSA Strategic Lead (Chief Superintendent, Norfolk Police) NSCB Workforce Development Manager	Apr 2016 May 2016
3	**OWNERSHIP**	Children's Social Care assure NSCB that its systems are now sufficiently efficient so as to ensure that a manager's decision to initiate an child protection conference cannot be 'lost' even if the staff allocated to the case are absent through illness or any other reason.	• Report on child protection conference systems provided • Audit on CP conference cases managed in teams where there is high absence or significant flux	Director of Children's Services, AD Social Care & Head of QA	May 2016

Achieving change through policy and procedure, continued					
Rec No.	**THEME**	**ACTIONS**	**Evidence/Mechanism**	**Owner**	**Timescales**
5	**FORA FOR DISCUSSION & INFO SHARING**	The 'County Attendance Guidance and Pro-forma for 'fast-track' meetings revised to ensure that: • Consideration is given to family history and past Service involvement • All plans to address poor school attendance identify and establish clear, understandable and measurable outcomes • Any medical evidence offered is reviewed to consider whether it justifies the level of absence • If there is evidence to suggest that medical needs are the cause of poor school attendance, a further plan should be developed to address those needs at the point of closing a 'fast track' case • The reason for case closure is clearly recorded in the minutes of the School Attendance panel	• Revised Guidance and Pro-forma competed • Revisions included in all training materials • MI to disseminate changes sent to all schools • Changes to procedures sent to relevant partners • Audit of plans and closed cases to quality assure planning, record keeping and communication systems with partners, including number of professionals meetings triggered	Children's Services Education Safeguarding Adviser and AD Education	Jul 2016 for implementation in Sep 2016
8	**FORA FOR DISCUSSION & INFO SHARING**	Further guidance developed for schools to inform and facilitate the support of vulnerable pupils by: • Recording all communication with other agencies Implementing communication systems within school so that all relevant safeguarding and attendance information is shared with staff who are working with a pupil			

Achieving change through policy and procedure, continued					
Rec No.	**THEME**	**ACTIONS**	**Evidence/Mechanism**	**Owner**	**Timescales**
6	**PROF CURIOSITY**	Supervision arrangements for Attendance Support and Enforcement Officers to be reviewed and strengthened so that: • Staff are better supported to consider case history and be more reflective in their practice • There is management accountability for all casework • Record keeping should demonstrate that case history has been considered and impacted upon decision making in supervision	Policy reviewed with evidence of any changes and amendments. Training programme implemented to disseminate changes to procedures for managers and Attendance Service staff	Children's Services Education Safeguarding Adviser and AD Education	May 2016
10	**COLLABORATIVE WORKING & DECISION MAKING**	Develop a Standard Operational Policy (SOP) for HCP workforce to underpin safe practice in responding to notifications from Police about domestic abuse where children have been identified.	• Guidance produced • Data on notifications from police to school nurses provided	CCS – Service Director, CYP Health Services	Aug 2016
11	**PROF CURIOSITY**	GP Practices to routinely discuss at clinical meetings the cases of children who have high consultation rates and record outcomes of discussions on the child's record.	• Guide developed to identify children with a high consultation rate, prompts for discussion and recording. • Audit tool developed	NHS Designated Safeguarding Team – Named GP	Oct 2016

Achieving change through policy and procedure, continued					
Rec No.	**THEME**	**ACTIONS**	**Evidence/Mechanism**	**Owner**	**Timescales**
12	**COLLABORATIVE WORKING & DECISION MAKING**	GP practice safeguarding policies reviewed to incorporate detailed processes for responding to 'safeguarding enquiries', including sharing (with all relevant staff) of relevant information about parents and other household members, information about the child and should also include recording of risks to the child on her/his record	Policy review check Audit tool to include: • policy implementation • recording systems to QA A&E notifications and discharge from CAMHS	NHS Designated Safeguarding Team – Named GP	Oct 2016
13	**OWNERSHIP**	Notifications from A&E or other sources indicating that an individual has been injured as a result of domestic abuse should be recorded on the patient's records summary, and should also be recorded on the summary of children in the household (which for 'SystmOne' users is on the 'safeguarding template)			
14	**OWNERSHIP**	GP Practices should have robust systems to ensure that notifications of discharge of children from CAMHS Tier 2 or other services because of parental non-engagement, trigger a re-assessment of the child's welfare and needs and any relevant follow-up			

Achieving change through workforce development and training					
NSCB Strategic Response: What difference do we expect to see? • Training materials updated to reflect policy change • Training impact assessments undertaken • Best Practice events delivered to disseminate learning to managers					
Rec No.	**THEME**	**ACTIONS**	**Evidence/Mechanism**	**Owner**	**Timescales**
1	**COLLABORATIVE WORKING & DECISION MAKING**	Best Practice workshop delivered to managers to disseminate any changes to policy review and promoting learning around 'modus operandi' of known sex offenders, including: • disruption methodology • risk management • joint protocol for managing absences	• Best Practice event evaluations • Impact assessment follow up	NSCB Business anager & Workforce Development Manager	Jul 2016 Nov 2016
2	**PROF CURIOSITY**				
5 & 8	**FORA FOR DISCUSSION & INFO SHARING**	Revised County Attendance Guidance and Pro-forma for 'fast-track' meetings is included in training materials, including further guidance on communicating with partners	Training impact assessment	Adviser – Education Safeguarding	Sep 2016
6	**PROF CURIOSITY**	Managers of attendance support and enforcement officers trained in refreshed supervision arrangements to ensure: • Staff are better supported to consider case history and be more reflective in their practice • Management accountability • Record keeping	• Training programme provided to demonstrate how this is included in workforce development planning • Evidence of number/% of managers trained • Training impact assessment	Children's Services Adviser – Education Safeguarding and AD Education	May 2016
7	**PROF CURIOSITY**	Training (focusing on the learning from this case and implications for management of school attendance) to be provided to Attendance Service staff and offered to 'attendance leads' in schools.	• Training programme provided to demonstrate how this is included in workforce development planning • Evidence of number/% of Attendance Service staff trained • Training impact assessment	Children's Services Adviser – Education Safeguarding and AD Education	Sep 2016

Achieving change through workforce development and training, continued					
Rec No.	**THEME**	**ACTIONS**	**Evidence/Mechanism**	**Owner**	**Timescales**
9	**PROF CURIOSITY**	Develop and deliver a programme of workshops for 0-19 HCP teams on Domestic Abuse which will include: risk management information sharing and professional analysis.	• Public Health as commissioner provided with assurance that this is included in workforce development planning • Evidence of number/% of school nurses trained	Director of Public Health CCS – Service Director, CYP Health Services	Aug 2016
10	**COLLABORATIVE WORKING & DECISION MAKING**				
16	**PROF CURIOSITY**	Mandatory specialist training to be commissioned and provided to all operational social workers and managers about working with adults known to pose a risk to children.	Effectiveness of the training assured by: • management overview • supervision • appraisal • case audits	Children's Services Principal Social Worker, Head of QA and AD Performance & Quality	Ongoing
	OWNERSHIP	All relevant staff are reminded of the information and guidance (Norfolk Safeguarding Children Board Policy Manual section 9.1) to support the management of risk posed by individuals with convictions against children	Information relating to this case is disseminated through: • Children's Services colloquium • Internal communications		April 2016

Achieving change through locality working and sector specific Advisory Groups					
NSCB Strategic Response: What difference do we expect to see? • Local Safeguarding Children Groups (LSCGs) and Advisory Groups for Health, Education and District Councils take learning forward and are accountable for monitoring impact in their areas/sectors • Agencies disseminate learning through safeguarding reporting, newsletters and events, including the Children's Services quarterly colliquium					
Rec No.	**THEME**	**ACTIONS**	**Evidence**	**Owner**	**Timescales**
4, 6 & 7	**PROF CURIOSITY**	Learning from this case relating to attendance management and revised County Attendance Guidance and Pro-forma for 'fast-track meetings'- and any actions arising - is taken forward, disseminated and monitored by the Education Safeguarding Adviser and Education Advisory Group	• Minutes Education Advisory Group • MI to schools • Education training programme	Chair Education Advisory Group & Education Safeguarding Adviser	Sep 2016
5 & 8	**FORA FOR DISCUSSION & INFO SHARING**				
9 & 11	**PROF CURIOSITY**	Learning from this case relating to high consultations, training of school nurses, and GPs' understanding of attendance issues, -and any actions arising - is taken forward, disseminated and monitored by the Health Advisory Group	• Minutes of Health Advisory Group • Quality Dashboard • Section 11 returns	Chair Health Advisory Group	Oct 2016
10 & 12	**COLLABORATIVE WORKING & DECISION MAKING**				
16	**PROF CURIOSITY** **OWNERSHIP**	Learning from this case and specialist training on working with adults known to pose a risk to children promoted at Children's Services colloquium	• Colloquium agenda • Internal newsletter • Numbers/% staff trained • Section 11 return	Children's Services Head of QA and AD Performance	Jul 2016
ALL	**VOICE OF THE CHILD**	LSCGs and Advisory Groups disseminate learning in their local areas/sectors	• Minutes of meeting • Evidence of other promotional events	LSCG and Advisory Group Chairs	Apr 2016 ongoing
ALL	**VOICE OF THE CHILD**	Report and summary PowerPoint published on NSCB website on publication NSCB undertakes roadshows to disseminate learning from this SCR	• Website hits to measure downloads • Roadshow evaluations	NSCB Business Manager & Workforce Development Officer	Mar 2016 Autumn 2016

Achieving change through audit and monitoring					
NSCB Strategic Response: What difference do we expect to see? • Robust auditing provides evidence of systemic change and improvement • Actions arising are taken forward to ensure continuous improvement • Standards of practice rise as a result of scrutiny and evidence is available to hold agencies to account					
Rec No.	**THEME**	**ACTIONS**	**Evidence**	**Owner**	**Timescales**
3	**OWNERSHIP**	Audit on CP conference cases managed in teams where there is high absence or significant flux	Audit report presented to PIQAG and Children's Services Performance & Challenge Board	Head of QA, AD Performance & Quality	Sept 2016
4	**PROF CURIOSITY**	Norfolk County Council Education Inclusion Service to audit the 'Attendance Service' casework in order to evaluate: • Recording • Quality of plans including timescales • Supervision • Outcomes for the child • Case closure	Audit report presented to PIQAG including timescales for implementing any subsequent recommendations for improvement	Children's Services Adviser – Education Safeguarding and AD Education	Completed Oct 2015
6 & 7	**PROF CURIOSITY**	Education Safeguarding Adviser to undertake training impact assessment on: • Updated supervision arrangements for managers responsible for attendance tracking • Attendance Enforcement Officers and attendance leads in schools • Revised County Attendance Guidance and Pro-forma for 'fast-track meetings'	• Training impact assessment report presented to PIQAG & Education Advisory Group • Numbers/% staff trained	Education Safeguarding Adviser and AD Education	Oct 2016
5 & 8	**FORA FOR DISCUSSION & INFO SHARING**				

Achieving change through audit and monitoring, continued					
Rec No.	**THEME**	**ACTIONS**	**Evidence**	**Owner**	**Timescales**
11	**PROF CURIOSITY**	Audit of GP practices' implementation of the guide to identify children with a high consultation rate, prompts for discussion and recording. To include: • policy implementation relating to responding to safeguarding enquiries and sharing information • notifications from A & E children have been injured as a result of domestic • notifications of discharge from CAMHS due to non-engagement	Audit report presented to PIQAG & Health Advisory Group including timescales for implementing any subsequent recommendations for improvement	NHS Designated Safeguarding Team – Named GP	Oct 2016
12	**COLLABORATIVE WORKING & DECISION MAKING**				
13 & 14	**OWNERSHIP**				
16	**PROF CURIOSITY**	• Training impact assessment undertaken to monitor operational social workers and managers understanding of working with adults known to pose a risk to children • Case file audit	• Training impact assessment report presented to PIQAG & CS Performance & Challenge Board • Numbers/% staff trained • Audit reports	Children Services Principal Social Worker and Head of QA	Sep 2016